

### BNURS506 Quiz Answering

**Term:** Spring 2025

**Module 3:** Cardiovascular & Pulmonary Systems

**Name:** Student F

#:	Your Answer	Feedback from Grader	Score
2	<p>To treat this patient's tension pneumothorax, I would expect the patient to get an immediate needle decompression or catheter/chest tube thoracostomy with a chest tube placed to water seal or suction (Lee, 2025). Alternatively, if the patient's presentation is less severe, treatment could include aspiration with a catheter and having the air manually aspirated and removed from the pleural space, depending on the severity of the tension pneumothorax (Lee, 2025).</p> <p>As the patient improves, some assessment findings I would expect include clearer breath sounds, decreased pain, stable vital signs including improved/no tachycardia and increased O2 saturation, improved work of breathing (minimal to no dyspnea), improved or lack of tracheal/mediastinal shift, and lung re-expansion based on X-ray imaging.</p> <p style="text-align: center;">References:</p> <p>Lee, Y. C. G. (2025). Clinical presentation and diagnosis of pneumothorax.</p> <p style="text-align: center;"><i>UpToDate</i>. Retrieved April 29, 2025, from <a href="https://www-uptodate-com.offcampus.lib.washington.edu/contents/clinical-presentation-and-diagnosis-of-pneumothorax?sectionName=Pneumothorax%20appearance%20and%20types&amp;search=tension%20pneumothorax%20">https://www-uptodate-com.offcampus.lib.washington.edu/contents/clinical-presentation-and-diagnosis-of-pneumothorax?sectionName=Pneumothorax%20appearance%20and%20types&amp;search=tension%20pneumothorax%20</a></p>	<p>Excellent explanation of treatment for a tension pneumothorax. I was looking for specific discussion surrounding the placement and management of a chest tube. One assessment finding that was not discussed in regards to chest tube management was the presence of an air leak and how the assessment of the air leak reducing overtime is an indicator that the pneumothorax is decreasing and healing, so I am deducting one point. And thank you for the feedback!</p>	9 / 10

	<p><a href="#">treatment&amp;topicRef=117232&amp;anchor=H3077927326&amp;source=see_link# H3077927326</a></p> <p>Feedback: I liked that this question is clear and concise. It is apparent what the question is asking and what information you want the reader to learn. One way you could improve the question is to include a photo of a tension pneumothorax.</p>		
4	<p>Alphee appears to have active TB (tuberculosis). When rooming Alphee, he would need to be put into a negative pressure room on airborne isolation precautions until his diagnosis is confirmed since TB is an airborne disease, and he could infect other patients when he coughs, sneezes, or talks.</p> <p>Alphee would first need a confirmed diagnosis of TB, which can include chest X-ray and sputum testing for acid-fast bacilli (AFB) smear, mycobacterial culture, and nucleic acid amplification (NAA) testing (Bernardo, 2024). Additional tests, such as an interferon-gamma release assay (IGRA) blood test and tuberculin skin test, could also be performed (Bernardo, 2024). Once diagnosed, TB is treated with antibiotics which can include isoniazid, rifampin, pyrazinamide, or ethambutol (Sterling, 2025). There usually are two phases in TB treatment regimens, which include an intensive phase (administration of 4 drugs for 2 months) and a continuation phase (administration of 2-3 drugs for 2-7 months) (Sterline, 2025). These antibiotics need to be taken daily, and the patient should not stop these medications early as it could result in multi-drug-resistant TB. This patient may also be assigned individual case management with direct observed therapy (DOT) to ensure they are taking medications appropriately and safely to prevent drug resistance (Sterline, 2025). DOT requires assigning a trained healthcare worker to observe patients taking their medications and monitoring for any side effects. Hepatotoxicity is an adverse effect of these medications; therefore, routine liver function tests should be done (Sterling, 2025). Overall, once this patient is stable and their symptoms are generally managed inpatient, they can be discharged on the TB medication regimen with a strict plan in place with DOT to ensure they complete their course of antibiotics and have frequent monitoring.</p>	<p>Great work. You have included all the answers I was looking for. The question about the considerations, plan of treatment and disposition can come vague and tricky to RNs who do not have ED background but I like how you included ED plan of care and DC plan of care. Good job. I also like that all of your references are more updated.</p>	10/ 10

References:

Bernardo, J. (2024). Diagnosis of pulmonary tuberculosis in adults. *UpToDate*.

Retrieved April 29, 2025, from

<https://www-uptodate-com.offcampus.lib.washington.edu/contents/diagnosis-of-pulmonary-tuberculosis-in-adults?search=tuberculosis%20&source=search>

[\\_result&selectedTitle=2%7E150&usage\\_type=default&display\\_rank=2](https://www-uptodate-com.offcampus.lib.washington.edu/contents/diagnosis-of-pulmonary-tuberculosis-in-adults?search=tuberculosis%20&source=search_result&selectedTitle=2%7E150&usage_type=default&display_rank=2)

Sterling, T. R. (2025). Treatment of drug-susceptible pulmonary tuberculosis in nonpregnant adults without HIV infection. *UpToDate*. Retrieved April 29, 2025, from

<https://www-uptodate-com.offcampus.lib.washington.edu/contents/treatment-of-drug-susceptible-pulmonary-tuberculosis-in-nonpregnant-adults-without-hiv-infection>

[search=tuberculosis%20treatment%20&source=search\\_result&selectedTitle=1%7E150&usage\\_type=default&display\\_rank=1#H3263247139](https://www-uptodate-com.offcampus.lib.washington.edu/contents/treatment-of-drug-susceptible-pulmonary-tuberculosis-in-nonpregnant-adults-without-hiv-infection?search=tuberculosis%20treatment%20&source=search_result&selectedTitle=1%7E150&usage_type=default&display_rank=1#H3263247139)

Feedback:

I liked that this question encouraged me to apply knowledge about TB in multiple ways including initial considerations during admission, treatment, and disposition after seeing this patient. There are many things to consider and including a question on treatment/medications was helpful as well. The photo was also a great way to clearly highlight the signs/symptoms of TB.

6	<p>The two oxygen saturation probes are placed on the right hand (preductal) and either foot (postductal). In utero, fetuses develop different pathways that redirect blood away from the lungs since they don't need to use them in the uterus (Banasik &amp; Copstead, 2018). The placenta supplies all the oxygen the baby needs in utero, which is why these pathways form in the heart. Once baby is born, these pathways normally close on their own, but if they don't, it can cause blood to flow abnormally and result in critical congenital heart disease (CHD) (Banasik &amp; Copstead, 2018). The first probe is placed on the right hand and is called preductal because oxygenated blood from the aorta flows there directly prior to where the ductus arteriosus is located (Oster, 2025). The ductus arteriosus is one of the fetal pathways developed in utero that connects the pulmonary artery and the aorta (Banasik &amp; Copstead, 2018). The second probe on either foot is called post-ductal because the blood that flows there from the heart is located after the ductus arteriosa connection (Oster, 2025). This placement is important because the differences in oxygenation readings can indicate what kind of critical CHD the baby has (Oster, 2025). For example, CHD is characterized by shunts (an abnormal path of blood flow) or obstructions (abnormal narrowing that inhibits blood flow) (Banasik &amp; Copstead, 2018).</p> <p>When the ductus arteriosus (DA) remains open, it causes oxygenated blood from the aorta to flow back into the pulmonary artery and directs extra blood into the lungs (Banasik &amp; Copstead, 2018). For some CHD, keeping the DA open is important to keep the baby oxygenated which is why prostaglandin is given. Some heart lesions can obstruct/limit blood flow to the pulmonary system (lungs) or systemic circulation (body) and can severely affect the amount of oxygenated blood a baby receives (Banasik &amp; Copstead, 2018). Monitoring the baby in two places allows us to determine how much oxygen they are receiving from their blood, whether keeping the DA open is working, and how to diagnose which CHD the baby has.</p> <p style="text-align: center;">References: Banasik, J. L., &amp; Copstead, L. E. (2018). <i>Pathophysiology</i>. Elsevier Inc.</p>	<p>GRADING CRITERIA:</p> <ol style="list-style-type: none"> <li>1. Correct placement of sat probes</li> <li>2. Rationale for placement</li> <li>3. An explanation that the baby likely has a ductal dependent lesion and needs a PDA (patent ductus arteriosus) in order to survive until surgery.</li> <li>4. Explanation of blood mixing leading to the different sat measurements</li> <li>5. APA formatting</li> </ol> <p>You did a great job answering this question, including explaining fetal circulation and identifying the correct placement and rationale of the sat probes. The clue in this question was that the baby was on prostaglandin, which you mentioned was important to keep the DA open for some <i>ductal-dependent lesions</i>.</p> <p>Thank you for the feedback. A picture of a fetal heart would have been great. I didn't think of that! I was looking at images of heart defects and they all gave away the answer, but your idea is a great one.</p>	10/ 10

	<p><a href="https://ebookcentral.proquest.com/lib/washington/detail.action?docID=5434807">https://ebookcentral.proquest.com/lib/washington/detail.action?docID=5434807</a></p> <p>Oster, M. (2025). Newborn screening for critical congenital heart disease using pulse oximetry. <i>UpToDate</i>. Retrieved April 29, 2025, from <a href="https://www-uptodate-com.offcampus.lib.washington.edu/contents/newborn-screening-for-critical-congenital-heart-disease-using-pulse-oximetry?search=pulse%20oximetry%20screening%20neonates&amp;source=search_result&amp;selectedTitle=1%7E150&amp;usage_type=default&amp;display_rank=1#H1212693478">https://www-uptodate-com.offcampus.lib.washington.edu/contents/newborn-screening-for-critical-congenital-heart-disease-using-pulse-oximetry?search=pulse%20oximetry%20screening%20neonates&amp;source=search_result&amp;selectedTitle=1%7E150&amp;usage_type=default&amp;display_rank=1#H1212693478</a></p> <p style="text-align: center;">Feedback:</p> <p>This question challenged me to think about neonatal and adult circulatory systems which initially was difficult since I don't work with the pediatric population daily. The question was a good blend of assessment application, pathophysiology, and patient teaching. One thing you could do to add more detail to this question would be to include a photo of the physiology of a fetal heart to demonstrate the differences in anatomy.</p>		
8	<p>Jenny most likely has postural orthostatic tachycardia syndrome (POTS). POTS is diagnosed through a table tilt test or standing test, but in Jenny's case a standing test was conducted (Gelfand et al., 2024). During a standing test, the patient's vital signs are taken in a supine position, and then they are asked to stand upright for 10 minutes, with vitals being checked at the end of this time (Gelfand et al., 2024). If there's an increase in heart rate by 30bpm or more without orthostatic hypotension (positive standing test), presence of worsening</p>	<p>You did a great job of properly identifying POTS and addressing every portion of the question. Fun fact, while Adderall can increase HR, it is also sometimes used to treat the chronic fatigue that can be seen with POTS. If I could give you a 12/10 for your answer, I would!</p>	10/ 10

<p>symptoms in an upright position, and symptoms are chronic lasting more than 6 months, then a diagnosis can be made (Gelfand et al., 2024).</p> <p>Three lifestyle modifications that can improve her symptoms include</p> <ol style="list-style-type: none"> <li>1. Increasing salt and fluid intake – Salt and fluids can help increase blood volume which can assist with blood pressure regulation, and decrease pooling of blood in the lower extremities upon standing, which could contribute to her dizziness and tachycardia (Gelfand et al., 2024).</li> <li>2. Wearing compression socks and other compression garments —Compression socks can prevent venous pooling in the lower extremities upon standing due to gravity shifts and encourage consistent blood flow throughout the body during positional changes (Gelfand et al., 2024).</li> <li>3. Avoid Triggers – If Jenny can pinpoint her triggers and avoid them, this will help exacerbate her POTS symptoms. Some triggers could include excess exposure to heat, standing for long periods, excess alcohol intake, and certain medications (Gelfand et al., 2024). Jenny takes Adderall daily, and as a stimulant, the medication could increase her HR, contributing to the tachycardia already present in POTS. Therefore, it may be beneficial to stop this medication.</li> </ol> <p>Bonus: There isn't one exact cause of POTS, but instead, there can be multiple physiological responses that contribute to POTS. One physiological mechanism is neuropathic, where the sympathetic nervous system is interrupted and impacts vascular constriction when a person is upright (Gelfand et al., 2024). By inhibiting vascular constriction, this can cause blood to pool in the lower extremities, causing sympathetic activation and tachycardia (Gelfand et al., 2024). Since Jenny has Ehlers-Danlos syndrome, this can impact her vascular connective tissue and impact blood vessel function (constriction), leading to pooling in the lower extremities as well (Gelfand et al., 2024).</p> <p style="text-align: center;">References:</p> <p>Gelfand, E., van Zuure, E. J., Oettgen, P. (2024). Postural tachycardia syndrome. <i>DynaMedex</i>. Retrieved April 29, 2025, from</p>	<p>Grading Criteria:</p> <p>2/2: proper identification of POTS</p> <p>2/2: identifying the tilt-table test as testing to confirm/diagnose the condition</p> <p>6/6: lifestyle modifications with brief rationale (2 points each)</p> <p>Bonus: 2/2, the answer properly describes one of the potential physiological mechanisms that causes POTS</p>	
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	<p><a href="https://www-dynamedex-com.offcampus.lib.washington.edu/condition/postural-tachycardia-syndrome-pots#GUID-F6018152-12C3-409B-A394-9AAB93F81F42">https://www-dynamedex-com.offcampus.lib.washington.edu/condition/postural-tachycardia-syndrome-pots#GUID-F6018152-12C3-409B-A394-9AAB93F81F42</a></p> <p>Feedback:</p> <p>I liked how this question included a lot of background information to help determine Jenny's diagnosis. The contextual clues were helpful, especially the inclusion of the standing test which helped clarify the diagnosis. I also liked how this question focused on application from multiple perspectives.</p>		
10	<p>Peter appears to have bacterial endocarditis based on the mitral valve vegetation present on the TEE. He also has symptoms indicative of bacterial endocarditis, including fever, fatigue, increased oxygenation, dyspnea, and a murmur, on top of the fact that he is at increased risk for endocarditis while using injectable drugs, such as heroin (Ball et al., 2023). To treat his endocarditis, he would be started on antibiotics based on his blood culture results (Wang &amp; Holland, 2024). Complications to watch out for could include congestive heart failure, sepsis, valvular regurgitation, embolic events, various malignant arrhythmias, and death (Wang &amp; Holland, 2024).</p> <p>References:</p> <p>Ball, J. W., Dains, J. E., Flynn, J. A., Solomon, B. S., &amp; Stewart. R. W. (2023). <i>Seidel's guide to physical examination</i>. Elsevier Inc.</p> <p><a href="https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/book/3-s2.0-B9780323761833000231?scrollTo=%23top">https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/book/3-s2.0-B9780323761833000231?scrollTo=%23top</a></p>	<p>Awesome job identifying the underlying diagnosis and how you would go about treating it. You have also identified important complications one should be aware of while treating a patient like this. Thank you for your feedback!</p>	10/ 10

	<p>Wang, A., &amp; Holland, T. L. (2024). Overview of management of infective endocarditis in adults. <i>UpToDate</i>. Retrieved April 30, 2025, from <a href="https://www-uptodate-com.offcampus.lib.washington.edu/contents/overview-of-management-of-infective-endocarditis-in-adults?search=bacterial%20endocarditis%20&amp;source=search_result&amp;selectedTitle=1~150&amp;usage_type=default&amp;display_rank=1#H1719465350">https://www-uptodate-com.offcampus.lib.washington.edu/contents/overview-of-management-of-infective-endocarditis-in-adults?search=bacterial%20endocarditis%20&amp;source=search_result&amp;selectedTitle=1~150&amp;usage_type=default&amp;display_rank=1#H1719465350</a></p> <p style="text-align: center;">Feedback:</p> <p>I liked how you included a picture from the TTE to assist with diagnosis. This question helped me apply knowledge of contextual information, diagnostic imaging, and patient presentation to determine diagnoses and next steps.</p>		
12	<ol style="list-style-type: none"> <li>1. The EKG shows that John has a ST-elevation myocardial infarction (STEMI) based on the presence of ST elevation at V1 and V2.</li> <li>2. The labs that should be attained include troponin, CK-MB, CBC, BMP, and renal function tests.</li> <li>3. Based on John's medical history, symptoms, and EKG, he had a STEMI heart attack, which is caused by a blockage of a coronary artery (Ball et al., 2023). Typical signs/symptoms related to a myocardial infarction include chest pain/tightness that could radiate to the jaw/neck (i.e. his toothache), fatigue, hypertension, and ST elevation in at least two leads on EKG (Ball et al., 2023). John's history of smoking, hypertension, and hyperlipidemia are also all risk factors for an MI.</li> <li>4. Treatments and medications to treat John's condition would focus on preventing further coronary artery thrombosis, minimizing myocardial injury,</li> </ol>	<ol style="list-style-type: none"> <li>1.1/1 Identifying ST elevation</li> <li>2.2/2 you got it!</li> <li>3.3/3 The explanation ties together the patient's history, symptoms, and EKG.</li> <li>4.4/4 Detailed and well organized!</li> </ol>	10/ 10

and treating the symptoms of his MI (Reeder & Kennedy, 2025). Two medications John could receive are aspirin, to prevent blood clots, and nitrates (nitroglycerin), to vasodilate blood vessels and improve blood flow to the heart (Reeder & Kennedy, 2025). Two treatments could include initiating reperfusion with percutaneous coronary intervention (PCI) or fibrinolysis to restore blood flow to the occluded coronary artery rapidly, and treating MI symptoms such as chest pain with opioids (eg. Morphine), ensuring adequate oxygenation, and managing arrhythmias (Reeder & Kennedy, 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.offcampus.lib.washington.edu/#!/content/book/3-s2.0-B9780323761833000231?scrollTo=%23top>

Reeder, G. S., & Kennedy, H. L. (2025). Overview of the acute management of ST-elevation myocardial infarction. *UpToDate*. Retrieved April 30, 2025, from

[https://www-uptodate-com.offcampus.lib.washington.edu/contents/overview-of-the-acute-management-of-st-elevation-myocardial-infarction?search=STEMI&source=search\\_result&selectedTitle=1~150&usage\\_type=default&display\\_rank=1](https://www-uptodate-com.offcampus.lib.washington.edu/contents/overview-of-the-acute-management-of-st-elevation-myocardial-infarction?search=STEMI&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1)

Feedback:

	<p>I liked how this question incorporated an EKG to encourage us to utilize our tele reading skills and apply that knowledge to determine a diagnosis. This question guided the reader through each step of the assessment, diagnosis, and treatment process which is great! To improve your question, just make sure to read through it a few times to ensure there's no grammatical mistakes and reads the way you intend it to.</p>		
14	<p>1. This patient may be having acute decompensated heart failure (ADHF) or the general acute worsening of his chronic heart failure. Since this patient has a history of CHF and pulmonary HTN that could explain many of his symptoms including SOB, wheezing, activity intolerance, chest pain, palpitations, and pain/numbness in BLE as a result of increased fluid retention and pulmonary congestion (Ball et al., 2023). Many of his symptoms are indicative of left-sided heart failure, such as SOB, fatigue, orthopnea, exercise intolerance, and wheezing because of pulmonary congestion (Ball et al., 2023). This could hinder his perfusion overall and result in the pain and numbness experienced in his BLE.</p> <p>2. This patient will most likely start on oxygen therapy since his O2 sat is 86 and he's having respiratory symptoms. Additional orders could include higher dose of IV diuretics to help treat his fluid overload, managing abnormal electrolytes to help prevent arrhythmias, and vasodilators to assist with increased pulmonary hypertension (Colucci, 2024). The doctor would also order many diagnostic tests and labs as listed below.</p> <p>3. The doctor will most likely order multiple tests including chest X-ray, ECG, echo, lung ultrasound, and CT (Meyer, 2024). Lab work that may be ordered includes ABG, VBG, CBC, BMP, troponin, BNP, LFT, lactate, etc (Meyer, 2024). Once testing and lab results return, this could indicate an underlying reason this patient may have ADHF and, therefore, determine further treatment options.</p> <p>Some variations in lab values that could be seen in this patient include abnormal ABG/VBG results as indicated by his hypoxia, elevated CBC if there is an underlying infection causing the ADHF, hyponatremia due to fluid</p>	<p>Yes, all your answers are correct. This patient is experiencing CHF exacerbation given the history, the medication is not effective, increased shortness of breath indicating volume overload, that leads to pulmonary congestion, disrupting fluid balance in the body, leading to HF.</p> <p>I think you answered all the possible diagnoses that can be expected. The purpose of this question was to know what happens when the heart's pumping capacity fails, which you addressed perfectly in your answer.</p>	10/ 10

overload or as a result of his diuretics, hypokalemia due to taking torsemide at home, elevated BNP, normal or slightly elevated troponin, and potentially elevated LFTs if his pulmonary HTN is causing systemic congestion.

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.offcampus.lib.washington.edu/#!/content/book/3-s2.0-B9780323761833000231?scrollTo=%23top>

Colucci, W. S. (2024). Treatment of acute decompensated heart failure:

General considerations. *UpToDate*. Retrieved April 30, 2025, from

<https://www-uptodate-com.offcampus.lib.washington.edu/contents/treatment-of-acute-decompensated-heart-failure-general-considerations?search=acute>

<https://www-uptodate-com.offcampus.lib.washington.edu/contents/treatment-of-acute-decompensated-heart-failure-general-considerations?search=acute>

[\\_result&selectedTitle=2~150&usage\\_type=default&display\\_rank=2](https://www-uptodate-com.offcampus.lib.washington.edu/contents/treatment-of-acute-decompensated-heart-failure-general-considerations?search=acute)

Meyer, T. E. (2024). Approach to diagnosis and evaluation of acute

decompensated heart failure in adults. *UpToDate*. Retrieved April 30, 2025, from

<https://www-uptodate-com.offcampus.lib.washington.edu/contents/appr>

	<p>oach-to-diagnosis-and-evaluation-of-acute-decompensated-heart-failure -in-adults</p> <p>?search=acute%20on%20chronic%20heart%20failure%20&amp;source=search_result&amp;selectedTitle=1~150&amp;usage_type=default&amp;_rank=1#H1828327839</p> <p>Feedback:</p> <p>This question is definitely challenging because this patient has so many symptoms and past medical history that can all influence his overall state. I did have trouble piecing together what was happening because his symptoms indicate left sided heart failure, but CHF is also listed as one of his current diagnoses. Some clarification would have been helpful in terms of the kind of diagnosis this patient could have because there could be multiple cardiac conditions that could fit or overlap with this patients' symptoms.</p>		
16	<ol style="list-style-type: none"> <li>1. She may have Raynaud phenomenon.</li> <li>2. Raynaud phenomenon is a vascular response to cold temperature or emotional stress, which manifests as color changes in the skin of the fingers or toes (Ball et al., 2023). In this case, the coworker's fingers turn white when cold and can improve by warming up the hands. A typical episode of Raynaud phenomenon is characterized by skin turning white due to constricted blood flow and then blue, indicating tissue hypoxia from deoxygenated blood, followed by red once perfusion returns (Ball et al., 2023). The vasospasm episodes can last minutes to less than an hour, and rewarming helps shorten the length of vasospasm (Ball et al., 2023).</li> <li>3. This person appears to have primary Raynaud because it generally occurs in young, healthy individuals with no other underlying cause compared to secondary Raynaud, which is associated with underlying connective tissue</li> </ol>	<p>You did a great job answering all parts of the question. I'm glad that you find the question to be clear. I had other peers who thought that scenario was confusing.</p> <p>Thanks for your feedback! I think it's such a great idea to add a picture, which would have helped more people understand the question. I will keep that in mind next time!</p>	10 / 10

	<p>disorders or lupus (Ball et al., 2023). Since this person doesn't mention that she has other underlying health conditions, it would suggest that she has primary Raynaud. Additionally, in secondary Raynaud, ulcers can form on the tips of the fingers which this person does not describe (Ball et al., 2023).</p> <p>References: Ball, J. W., Dains, J. E., Flynn, J. A., Solomon, B. S., &amp; Stewart. R. W. (2023). <i>Seidel's guide to physical examination</i>. Elsevier Inc. <a href="https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/book/3-s2.0-B9780323761833000231?scrollTo=%23top">https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/book/3-s2.0-B9780323761833000231?scrollTo=%23top</a></p> <p>Feedback: I liked how this question is clear and encouraged the reader to utilize context clues to determine a diagnosis. The expectations were concise, and it is obvious what the question is asking. You could include a picture as well to help demonstrate the symptoms this person is having.</p>		
18	<p>1. Two factors that may have led Ron to develop a DVT include prolonged immobilization due to his recent abdominal surgery and his history of metastatic colon cancer. Both of these conditions are risk factors for developing DVT due to their association with the patient being in a hypercoagulable state, whether from recent surgery and limited mobility or cancer diagnosis that can increase inflammation, activate clotting factors, and treatment that could damage blood vessels (Huisman &amp; Bauer, 2025).</p> <p>2. To treat Ron's DVT, he would be started on an anticoagulant such as heparin or apixaban. These anticoagulants, also known as "blood thinners," help prevent the current clot from growing and prevent new clots from forming. Though these medications don't eliminate the clot itself, by preventing new clots and preventing the growth of clots, they decrease the risk of further complications while giving the body time to break down the DVT on its own.</p>	Great job on this! You clearly identified two reasons for the development of the DVT, the medications you'd expect Ron to be prescribed, and complications that can arise. I appreciate your use of in-text citations as well.	10/ 10

	<p>3. A complication that can arise from the DVT is a PE (Huisman &amp; Bauer, 2025). If part of the clot from the DVT dislodges from the leg, it can travel up into the lungs, causing a PE. This PE could then disrupt blood flow to the lungs, leading to symptoms such as shortness of breath, chest pain, cough, and hemoptysis. A PE can be life-threatening if left untreated.</p> <p style="text-align: center;">References:</p> <p>Huisman, M. V., &amp; Bauer, K. A. (2025). Clinical presentation and diagnosis of the nonpregnant adult with suspected deep vein thrombosis of the lower extremity. <i>UpToDate</i>. Retrieved April 30, 2025, from <a href="https://www-uptodate-com.offcampus.lib.washington.edu/contents/clinical-presentation-and-diagnosis-of-the-nonpregnant-adult-with-suspected-deep-vein-thrombosis-of-the-lower-extremity?search=deep%20vein%20thrombosis%20&amp;source=search_result&amp;selectedTitle=3~150&amp;usage_type=default&amp;display_rank=2">https://www-uptodate-com.offcampus.lib.washington.edu/contents/clinical-presentation-and-diagnosis-of-the-nonpregnant-adult-with-suspected-deep-vein-thrombosis-of-the-lower-extremity?search=deep%20vein%20thrombosis%20&amp;source=search_result&amp;selectedTitle=3~150&amp;usage_type=default&amp;display_rank=2</a></p> <p style="text-align: center;">Feedback:</p> <p>I liked that this question was written clearly and utilized a photo as well! We see DVTs often in the inpatient setting, and it was a great question to utilize knowledge and application of a phenomenon that can happen quite often to our patients.</p>		
20	<p>1. Abnormal findings that suggest complications other than airflow obstruction are jugular vein distension, lower extremity edema, and hepatomegaly. These complications are more suggestive of right sided heart failure or more specifically cor pulmonale since Robert has a history of COPD (Ball et al., 2023). Cor pulmonale can result from COPD due to increased pulmonary hypertension, making it more difficult for the right side of the heart to pump</p>	<p>Excellent answer that is comprehensive and clinically strong. You had a good explanation of cor pulmonale and pathophysiology. You clearly</p>	10/ 10

<p>blood efficiently into the lungs, leading to enlargement of the right ventricle and the presence of his new symptoms (Ball et al., 2023).</p> <p>2. It is important to differentiate whether Robert's symptoms are primarily from COPD progression versus a cardiac cause because that will help determine the method of treatment. His history of COPD can cause increased pulmonary hypertension which results in cor pulmonale and right sided heart failure that could progress into chronic heart failure if not treated appropriately (Ball et al., 2023). The cor pulmonale causes systemic venous congestion, resulting in hepatomegaly, JVD, and lower extremity edema (Ball et al., 2023). By impeding blood flow through the liver, this can lead to ascites which may be causing Robert's abdominal pain (Banasik &amp; Copstead, 2018). In general, managing the cor pulmonale symptoms could include fluid management utilizing diuretics and managing underlying pulmonary hypertension with vasodilators. As progressive COPD is the cause of cor pulmonale, Robert may also benefit from oxygen therapy. Overall, long term treatment of the cor pulmonale would require management of his COPD.</p> <p style="text-align: center;">References:</p> <p>Ball, J. W., Dains, J. E., Flynn, J. A., Solomon, B. S., &amp; Stewart. R. W. (2023). <i>Seidel's guide to physical examination</i>. Elsevier Inc.</p> <p><a href="https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/book/3-s2.0-B9780323761833000231?scrollTo=%23top">https://www-clinicalkey-com.offcampus.lib.washington.edu/#!/content/book/3-s2.0-B9780323761833000231?scrollTo=%23top</a></p> <p>Banasik, J. L., &amp; Copstead, L. E. (2018). <i>Pathophysiology</i>. Elsevier Inc.</p> <p><a href="https://ebookcentral.proquest.com/lib/washington/detail.action?docID=5434807">https://ebookcentral.proquest.com/lib/washington/detail.action?docID=5434807</a></p> <p style="text-align: center;">Feedback:</p> <p>This question was a great way to tie in the cardiac and pulmonary systems. Since these systems can relate and impact one another, the question</p>	<p>differentiated treatment implications and mentioned specific interventions. Nice job!</p>	
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	challenged the reader to understand the underlying pathophysiology of the patient's condition and be able to apply that knowledge for further diagnosis.		
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