BNURS506 Quiz Answering

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

#:	Your Answer	Feedback from Grader	Score
1	1. Severe testicular pain following recent strenuous activity would lead me to suspect that the 12-year-old male may have testicular torsion, an acute ischemic event caused by twisting of the spermatic cord resulting in obstruction of blood flow. If confirmed, testicular torsion requires emergency intervention within 4-8 hours of symptom onset to prevent permanent ischemic damage (Wiener et al, 2025). 2. I would assess the patient for erythema, swelling, and induration. Other signs I would look out for are high-riding testicle (Brenzel sign) or retraction of scrotal skin (Ger sign) (Weiner, 2025). I would also ask the patient when exactly the trauma happened and when exactly did his symptoms start. Knowing that this is likely an emergency, I would notify his parents then call an ambulance to take the child to the emergency room where I would expect them to perform emergent surgical exploration or manual detorsion. 3. As a nurse, I would tell my patient and their family that testicular torsion is a serious medical emergency that could result in tissue death, removal of testicle, and infertility. Sign and symptoms are sudden, severe pain in the testicle or scrotum that may be accompanied by nausea, vomiting, swelling, redness, and change in testicle position. To prevent permanent damage, seek emergent medical attention with 4-8 hours of symptom onset (Wiener, 2025). References: Wiener, J., Jolanda van Zuuren, E., & Barron, S. (2024). *UpToDate*. Retrieved from https://www-dynamedex-com/condition/testicular-torsion Feedback:	Correct identification of diagnosis. Calling the parents first in perfect, if they can't get the student then calling 911 would be warranted. Perfect patient education.	10/ 10

	This question was comprehensive and included pathophysiology, physical assessment, and patient education. I liked how questions were straight forward.		
2			/ 10
3	1. The patient's abdominal pain, bleeding, and vomiting likely indicates a ruptured ectopic pregnancy. The patient also has history of endometriosis and smoking which are risk factors (Tulandi, 2025). The ultrasounds likely saw no intrauterine gestational sac but could also see an adnexal mass near the fallopian tubes or pelvic free fluid (Brady et al, 2025). 2. Beta-human chorionic gonadotropin is produced as soon as 8 days after ovulation. Normally is increases than plateaus in a normal pregnancy. If B-hCG levels exceed the discriminatory zone and no intrauterine pregnancy is seen on transvaginal ultrasound, it would strongly indicate ectopic pregnancy (Brady et al, 2025). 3. If the patient had a salpingostomy, B-hCG should be followed to ensure there's no residual pregnancy tissue remaining (Brady et al, 2025). I would also assess for vaginal bleeding, s/s of infection or sepsis, pain management, and track H&H. References: Brady, P., Warren, M., Zuber, M., & Fedorowicz, Z. (2025). Ectopic pregnancy. *DynaMedex*. Retrieved from https://www-dynamedex-com/condition/ectopic-pregnancy Tulandi, T. (2025). Ectopic pregnancy: epidemiology, risk factors, and anatomic sites. *UpToDate*. Retrieved from https://www-uptodate-com /contents/ectopic-pregnancy-epidemiology-risk-factors-and-anatomic-sites Feedback: I appreciate learning about s/s of ectopic pregnancy so I could easily identify this in the future and provide prompt treatment. The first question was a bit confusing but overall, I was able to quickly find all the information I needed from a few resources.	I appreciate the feedback. I meant to make this scenario as easy as possible. The details and wording makes it difficult to understand. I will work on my writing skills. Thank you!	10/ 10
4			/ 10

5	1. The patient technically does not meet the criteria for infertility at her age, which is considered if unable to conceive after 1 year of unprotected intercourse (Warren et al, 2024a). 2. Based on her symptoms, I would consider endometriosis and polycystic ovary syndrome. a. Endometriosis is when endometrial tissue is present outside of the endometrial cavity. It presents with painful menses, pelvic/abdominal pain, and infertility. I would ask if she had other symptoms associated with endometriosis including pain during intercourse, cyclic dysuria, and GI issues (constipation, diarrhea, dyschezia) (Warren, et al, 2024b). b. PCOS is a heterogenous disorder characterized by ovulary dysfunction, hyperandrogenism, and polycystic ovarian morphology. It presents as irregular menses cycles, acne, and hirsutism. I would ask question about changes in weight, acne, or hair growth. I would also gather history regarding cycle irregularity and duration. PCOS is associated with female infertility (Brady et al, 2025). 3. One diagnostic I would anticipate is hormone level evaluation (midluteal serum progesterone, luteinizing hormone, follicle stimulating hormone, prolactin, thyroid-stimulating hormone, testosterone). Another diagnostic is a transvaginal ultrasound to detect endometriosis, masses, or adhesions (Warren et al, 2024a). References: Brady, P., Sivanandy, M., Fedorowicz, Z., & Ehrlich, A. (2025). Polycystic ovary syndrome. *DynaMedex.* Retrieved from https://www-dynamedex-com/condition/polycystic-ovary-syndrome-pcos Warren, M., Fedorowicz, Z., & DeGeorge, K. (2024). Female infertility. *DynaMedex*. Retrieved from https://www-dynamedex-com/condition/female-infertility Warren, M.,Greathouse, E., Fedorowicz, Z., & DeGeorge, K. (2024). Endometriosis. *DynaMedex*. Retrieved from https://www-dynamedex-com/condition/endometriosis	Fantastic work. You were succinct yet detailed and hit on all the assessments I'd ask of this patient as well. Thank you for the feedback. I don't like being too prescriptive– I was just looking for more than one diagnostic method.	10/ 10

	Feedback: This was a great comprehensive question. My only feedback is to be more specific with how many diagnostic evaluations you require. I wasn't sure if you wanted just one or more.		
6			/ 10
7	1. My priority nursing assessment would be to monitor vital signs especially fever since it may indicate the presence of necrotic tissue. I would also do a thorough pain assessment (location, intensity, radiation). My nursing interventions would be to provide pain management (pharm and non-pharm) and to prepare patient for possible emergency surgery (keep NPO and place IV) (Levine et al, 2025). 2. An abdominal ultrasound with doppler would be used to visualize ovarian torsion and determine blood flow to ovaries (Levine et al, 2025). An abdominal CT with contrast would be used to confirm appendicitis (Drake et al, 2024). 3. I would expect IV pain medication such as morphine and IV antiemetics such as ondansetron. 4. If this were an adult case, a transvaginal ultrasound may be used to visually confirm ovarian torsion. However, this is not used in pediatric patients or patients that are not sexually active (Levine et al, 2025). References: Drake, F., Martinex, R., Jolanda van Zuuren, E., & DeGeorge, K. (2024). Appendicitis in adolescents and adults. *DynaMedex*. Retrieved from https://www-dynamedex-com/condition/appendicitis-in-adolescents-and-adults Levine, E., Jolanda van Zuuren, E., & DeGeorge, K. (2025). Adnexal torsion. *DynaMedex*. Retrieved from https://www-dynamedex-com/condition/adnexal-torsion Feedback:	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 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 Great work! especially with the last part - you	/ 10

	I appreciate that your question focused specifically on the nursing assessment and interventions. I wasn't familiar with ovarian torsion prior to your question so I found it interesting.	are theonly one to call out this specific pediatric consideration	
8			/ 10
9	1. First, have the patient lie supine. Then, apply soft steady pressure to the LLQ. If the patient feels pain in the RLQ, the test is considered positive and likely indicates appendicitis due to gas pushing on the inflamed area near the appendix (McGee, 2022). 2. Other diagnostics work up would include (Drake et al, 2024): a. a pregnancy test to rule out pregnancy b. WBC with diff & CRP to look for severity of infection (elevated WBC, elevated CRP) c. Abdominal ultrasound + risk stratification d. Abdominal CT with contrast References: Drake, F., Martinex, R., Jolanda van Zuuren, E., & DeGeorge, K. (2024). Appendicitis in adolescents and adults. *DynaMedex*. Retrieved from https://www-dynamedex-com/condition/appendicitis-in-adolescents-and-adults McGee, S. (2022). *Evidence-based physical diagnosis* (5th ed.) Elsevier. Feedback: I appreciate the simplicity of this question. I felt it still required me to do a deep dive into appendicitis and I learned how to do perform a Rovsing test!	While I was reading your answer in question number 1, I knew that you got the question right and provided the right answer but I was looking for the specific name of the assessment which was not mentioned. When I looked at your feedback, you mentioned about you learning to perform the Rovsing test. This still gives you full credit. The adjuncts you provided are definitely the next steps for this patient. Congrats!	10/ 10
10			/ 10
11	1. Diarrhea with blood and mucus, tenesmus, rectal urgency, severe abdominal pain, fatigue, nausea, and unintentional weight loss are s/s of ulcerative colitis. Continuous inflammation from the colorectal further supports UC. 2. Treatment includes: a. IV Methylprednisolone or hydrocortisone	*Great job! All questions were answered accurately and completely. I appreciate your feedback and I apologize if it took you that long to answer it, definitely not my intention. The bright side of it is that we are done. No more questions to make ot to answer. Congrats!*	10/ 10

	i. The purpose is to induce remission by reducing inflammation in the digestive tract, used short-term for flare up ii. Used in hospitalized patients with acute severe UC (>6 bloody stool/day + systemic toxicity) b. 5-aminosalicylic acid i. The purpose is to reduce inflammation both short-term and long-term ii. Used as first-line treatment for mild-moderate active disease state c. Restorative proctocolectomy with ileal pouch-anal anastomosis i. The purpose is to remove the entire colon and rectum while preserving anal sphincter. Pt usually maintains continence and bowel function. ii. Used for patients with chronic refractory UC which is unresponsive to traditional medical therapy d. Total abdominal colectomy with end ileostomy i. The purpose is to remove the entire colon and leaves behind a defunctionalized rectum. An ileostomy will be used for bowel movement. ii. Used for patients with acute severe ulcerative colitis and either: 1. Have toxic megacolon, perforation, uncontrolled hematochezia, or multiorgan dysfunction 2. Fail to improve after 3-5 days of corticosteroids e. Regular monitor and procedures include: i. Fecal calprotein testing during active inflammation to assess response to therapy ii. If taking 5-ASAs, assess treatment response within 6 weeks and monitor for nephrotoxicity iii. Start colorectal cancer screening 8 years after UC diagnosis, surveillance colonoscopies 1-3 year intervals depending on risk factors and results.		

	iv. Monitor bowel movements daily (frequency, bloody, mucus present, additional symptoms) v. Assess colonoscopy 6-12 months after achieving remission to determine degree of mucosal healing. Obtain inflammatory markers at colonoscopy (CRP, fecal calprotein). Measure biomarkers every 6-12 months during remission References: Dalal, S., Weiner, B., Qaseem, A., & DeGeorge, K. (2025). Ulcerative colitis in adults. *DynaMedex*. Retrieved from https://www-dynamedex-com /condition/ulcerative-colitis-in-adults Fleshner, P. (2025). Surgical management of ulcerative colitis. *UpToDate*. Retrieved from https://www-uptodate-com/contents/surgical-management-of-ulcerative-colitis Hashash, J. & Regueiro, M. (2025). Medical management of low-risk adult patients with mild to moderate ulcerative colitis. *UpToDate*. Retrieved from https://www-uptodate-com/contents/medical-management-of-low-risk-adult-patients-with-mild-to-moderate-ulcerative-colitis Peppercorn, M. & Farrell, R. (2025). Management of the hospitalized adult patient with severe ulcerative colitis. *UpToDate*. Retrieved from https://www-uptodate-com/contents/management-of-the-hospitalized-adult-patient-with-severe-ulcerative-colitis Feedback: This question was thorough but very extensive. It required over an hour and used 4 sources to answer parts of this question. While this was a great deep dive into UC, it was overwhelming amount of work to do for just a single question out of the ten needed to complete the assignment.		
12			/ 10
13	1. Eosinophilic esophagitis is a chronic, immune/antigen-mediated condition in which eosinophils are become present in the	You were spot-on with this answer! Great work with identifying the	10/ 10

	esophagus lining due to a trigger, usually allergy (Rothenberg, 2025). This leads to inflammation and tissue changes (i.e strictures, rings) which cause dysphagia, food impaction, GERD-like symptoms, and upper abdominal pain (Bonis & Gupta, 2025a). Risk factors include family history especially in male relatives, atopic conditions such as asthma and eczema, and genetic disorders such as Marfan syndrome and Ehlers-Danlos syndrome (Barry et al, 2024). 2. Sam reports progressive dysphagia and chest discomfort while eating solid food which are symptoms of EoE. Sam also has a history of allergies, atopic dermatitis, and a family history of EoE in two male relavtives which are all risk factors for EoE. Together, his symptoms and risk factors would be of high suspicion for EoE. 3. Treatments can include: a. Proton pump inhibitors (PPIs) – Medication that reducing acid production in patients with coexistent GERD and have anti-inflammatory properties overall (Bonis & Gupta, 2025b). b. Dietary changes are first-line treatment for EoE. Identifying trigger foods and eliminating those from diet to prevent and reduce inflammation. Allergy testing can also be used to identify food triggers (Bonis & Gupta, 2025b). c. Topical glucocorticoid such as budesonide are used to reduce inflammation in the esophagus. Can be in the form of oral solution or inhaler (Bonis & Gupta, 2025b). References: Barry, K., Weiner, B., Fedorowicz, Z., & DeGeorge, K. (2024). Eosinophilic esophagitis in adults. *DynaMedex*. Retrieved from https://www.dynamedex.com/condition/eosinophilic-esophagitis-in-adults Bonis, P. & Gupta, S. (2025). Clinical manifestations and diagnosis of eosinophilic esophagitis. *UptoDate.* Retrieved from https://www-uptodate-com/contents/clinical-manifestations-and-diagnosis-of-eosinophilic-esophagitis-eoe	pathophysiology, medical/family history and possible management options. Your answers demonstrated your understanding of this diagnosis and I appreciated your use of in-text citations. Thanks for your feedback as well!	

	Bonis, P. & Gupta, S. (2025). Treatment of eosinophilic esophagitis. *UptoDate.* Retrieved from https://www-uptodate-com/contents/treatment-of-eosinophilic-esophagitis Rothenberg, M. (2025). Eosinophilic esophagitis (EoE): Genetics and immunopathogenesis. *UpToDate.* Retrieved from https://www-uptodate-com/contents/eosinophilic-esophagitis-eoe-genetics-and-immunopathogenesis Feedback: It was interesting to learn about this condition! Your question had a good balance of pathophysiology and condition management. Thank you for being specific about how concise you wanted the pathophysiology answer.		
14			/ 10
15	1. The patient likely has cirrhosis of the liver which is an end-stage liver disease characterized by pathologic advanced fibrosis that result in liver dysfunction. One of the common causes is alcohol misuse which applies to the patient who drinks 0.5L daily. Jaundice (yellowing of the skin and eyes), ascites, fatigue and encephalopathy that is present in the patient are common complications of cirrhosis (Schiff et al, 2025). 2. Ascites is a pathologic accumulation of fluid in the peritoneal cavity. A therapeutic large volume paracentesis that would remove access fluid, thereby decreasing abdominal distention and providing relief for the patient (Bechler et al, 2023). 3. Hepatic encephalopathy can be a result of high ammonia levels. Lactulose is used to reduce ammonia levels but have a laxative effect. Two pieces of education include: a. Side effects of medication are abdominal discomfort such as bloating, cramping, and nausea. b. The patient should have 2-3 bowel movements per day. The patient should be instructed to notify if they are having more than 3 stools as they can result in dehydration, hyponatremia, and worsening encephalopathy. References:	Amazing answer to this question! You have accurately diagnosed Earl given his clinical presentation. You have also accurately named and described the procedure he would receive to relieve the fluid buildup in his abdomen. Great job as well with your education points when administering the lactulose. Thank you so much for your feedback! I am so sorry to hear that you had a recent patient experience with this diagnosis that did not end well. Cirrhosis can be a very tough disease to manage, and patients can decompensate very suddenly.	10/ 10

	Bechler, K., Donovan, J., Robson, S., & Qaseem, A. (2023). Ascites. *DynaMedex.* Retireved from https://www.dynamedex.com/condition/ascites Duarte-Rojo, A., Robson, S., Bonder, A., & Qaseem, A. (2025). Hepatic encephalopathy. *DynaMedex.* Retrieved from https://www.dynamedex.com/condition/hepatic-encephalopathy Schiff, E., Mukherjee, S., Fedorowicz, Z., & DeGeorge, K. (2025). Cirrhosis of the liver. *DynaMedex.* Retrieved from https://www.dynamedex.com/condition/cirrhosis-of-the-liver Feedback: Coincidentally, I just had a patient with cirrhosis that ended up decompensating quickly and passed during my shift. I don't normally take care of patients with liver failure, so it was a good dive into the pathophysiology of alcoholic cirrhosis during this time. Thank you for your concise and clear question!		
16			/ 10
17	1. Tirzepatide is a dual glucose-dependent insulinotropic polypeptide (GIP) receptor and glucagon-like peptide-1 (GLP-1) receptor antagonist used to improve glycemic control in adults with type 2 diabetes. It reduces glucose by enhancing first- and second-phase insulin secretion, reducing glucagon levels, and slowly gastric emptying (Leung & Ehrlich, 2025). Because Ruth already has a history of gallstones, delayed gastric emptying from Tirzapatide could exacerbate this and cause acute calculous cholecystitis which is a known adverse effect (Dungan & DeSantis, 2024). 2. Tirzepatide is long acting and can have gastric delaying effects over days (Leung & Ehrlich, 2025). The ultrasound is to determine if the patient has residual gastric contents which is common with tirzepatide despite preoperative fasting and can have an increased risk of aspiration during anesthesia (Berkow, 2025). Postoperative nursing interventions include monitoring for delayed return of bowel function, holding oral intake till bowel sounds return, and starting slow with clear liquids before advancing diet.	Nice job answering this question! You described the physiology well, and great work identifying that it is not the cause of Ruth's cholecystitis, but is likely exacerbating her gallstones as a result of her history and intended effects of the medication. Nice work identifying the anesthesia considerations. I removed half a point, because I was really looking for aspiration precautions in the post-op period. All the things you mention are correct and would be important to pay especially careful attention to, but are still the standard of care for patients	9.5 / 10

	References: Berkow, L. (2025). Rapid sequence induction and intubation (RSII) for anesthesia. *UpToDate*. Retrieved from https://www-uptodate-com.offcampus.lib.washington.edu/contents/rapid-sequence-induction-and-intubation-rsii-for-anesthesia Dungan, K. & DeSantis, A. (2024). Glucagon-like peptide 1-based therapies for the treatment of type 2 diabetes mellitus. *UpToDate.* Retrieved from https://www-uptodate-com/contents/glucagon-like-peptide-1-based-therapies-for-the-treatment-of-type-2-diabetes-mellitus Leung, J. & Ehrlich, A. (2025). Glucagon-like peptide-1 (GLP-1) receptor agonists for adults with diabetes mellitus. *DynaMedex.* Retrieved from https://www.dynamedex.com/drug-review/glucagon-like-peptide-1-glp-1-receptor-agonists-for-adults-with-diabetes-mellitus Feedback: The question was more on the challenging side in terms of connecting pharmacology/pharmacokinetics to adverse side effects of a medication. But overall, it was interesting learning more because it's becoming more commonly used.	post abdominal surgery. Overall, great work, and thank you for your feedback!	
18			/ 10
19	1. The most likely diagnosis is an acute upper gastrointestinal bleed. It's described as a bleed in the GI tract that is proximal to the ligament of Treitz. This is likely due to the patient's history of peptic ulcer disease which causes sores in the stomach or duodenum and apixaban which is a blood thinner. Melena (dark, tarry stool) is a due to blood that is a digested indicating that the blood is from the upper GI tract. Weakness, dizziness, and low blood pressure could be a sign of anemia caused by the bleed (Abougergi et al, 2024). 2. Possible interventions include IV fluid administration for fluid resuscitation, blood transfusion for anemia, and course of high dose proton pump inhibitors to suppress gastric acid and support ulcer healing Abougergi et al, 2024).	1. Gastrointestinal (UGI) Bleeding. 2/2 Awesome, you got it. 2. Interventions*3. 6/6 Awesome!! you mention IV fluid, PPI, and blood transfusion. 3. nursing education*2. 2/2 That's good you mention sign of bleeding, and avoid NSAIDs	10/ 10

	3. Patient education can include: a. Prevent ulcers by avoiding NSAIDs b. Continue monitoring for melena and to notify doctor if they have melena, dizziness, or fatigue References: Abougergi, M., Jackson, C., Lang, E., & Trow, T. (2024). Acute nonvariceal upper geastrointestinal bleeding. *DynaMedex.* Retrieved from https://www.dynamedex.com/approach-to/acute-nonvariceal-upper-gastrointestinal-bleeding Feedback: This was a great, straight-forward question! I appreciate the clear instructions and the point breakdown.		
20			/ 10