Week 4: Midterm - Requires Respondus LockDown Browser + Webcam

POSSIBLE MID-TERM QUESTIONS

A 20-year-old male presents to your primary care clinic. This patient is a college student. He complains of fatigue, sore throat, and low-grade fever for 3 days. On physical exam, he has a temperature of 100.7°F. His ear exam is normal. His nose and throat exam shows mild erythema of the nasal mucosa and edematous, enlarged tonsils bilaterally, with erythema of the pharyngeal wall and tonsillar exudates. He has inflamed posterior cervical lymph nodes. He has a mild nonproductive cough and clear lung exam. What is his most likely diagnosis?

• Viral pharyngitis.

Mononucleosis (This presentation could be a viral pharyngitis; however, with posterior cervical lymphadenitis, you would suspect mononucleosis)

• Streptococcal pharyngitis.

• Upper respiratory infection.

Which of the following is not a complication of untreated group A streptococcal pharyngitis?

• Glomerulonephritis.

• Rheumatic heart disease.

• Scarlet fever.

Hemolytic anemia (This is a complication of mononucleosis)

Jonathan, age 19, has just been given a diagnosis of mononucleosis. Which of the following statements is true?

Antibiotic therapy should be instructed to avoid stress and that convalescence may take several weeks) utensils. Bed rest is necessary only in severe cases)

The virus that causes mononucleosis is transmitted through saliva,

hence the nickname the "kissing disease." It is contagious and can be transmitted through kissing or sharing

Jonathan should avoid contact sports and heavy lifting (When teaching clients about mononucleosis, or Epstein-Barr virus (EBV), tell them to avoid contact sports and heavy lifting because of splenomegaly and

a threat of rupture)

Mario, a 17-year-old high school student, came to the office for evaluation. He is complaining of persistent sore throat, fever, and malaise not relieved by the penicillin therapy prescribed recently at the urgent care center. As the nurse practitioner, what would you order next?

A Monospot test (If a client has a persistent sore throat, fever, and malaise not relieved by penicillin therapy, a Monospot test should be performed to rule out mononucleosis (Epstein-Barr virus)

Marcia, age 4, is brought in to the office by her mother. She has a sore throat, difficulty swallowing, copious oral secretions, respiratory difficulty, stridor, and a temperature of 102°F but no pharyngeal erythema or cough. What do you suspect?

Epiglottitis (A symptom cluster of severe throat pain with difficulty swallowing, copious oral secre tions, respiratory difficulty, stridor, and fever but without pharyngeal erythema or cough is indicative of epiglottitis)

You diagnose acute epiglottitis in Sally, age 5, and immediately send her to the local emergency room. Which of
the following symptoms would indicate that an airway obstruction is imminent?
• Reddened face.
• Screaming.
• Grabbing her throat.
Stridor (In a pediatric client with acute epiglottitis, a number of symptoms can indicate that airway obstruction is imminent: stridor, restlessness, nasal flaring, as well as the use of accessory muscles of respiration)

A patient asks how to avoid contracting pharyngitis and tonsillitis. Which piece of advice is not appropriate for this patient?

"Take antibiotics when well to avoid future infections." (Patients should only be prescribed antibiotics if a throat culture confirms disease of bacterial origin)

Which of the following is not recommended for hoarseness (Dysphonia)?
• Vocal rest.
• Tobacco cessation.
• Decrease in caffeine use.
Oral steroids (Oral steroids are not routinely used to treat hoarseness)

Samantha, age 12, presents with ear pain. When you begin to assess her ear, you tug on her normal-appearing auricle, eliciting severe pain. This leads you to suspect:
• Otitis media (membrane)
• Otitis media with effusion (Otitis media, with or without effusion, cannot be diagnosed without examining Otitis media, with or without effusion, cannot be diagnosed without examining the tympanic
the tympanic membrane).
Otitis externa (When severe pain is elicited by tugging on a normal-appearing auricle, an acute infection of the external ear canal (otitis externa) is suspected)
• Primary otalgia (Otalgia is ear pain)

Kathleen, age 54, has persistent pruritus of the external auditory canal. External otitis and dermatological conditions, such as seborrheic dermatitis and psoriasis, have been ruled out. What can you advise her to do?
• Use a cotton-tipped applicator daily to remove all moisture and potential bacteria.
• Wash daily with soap and water.
Apply mineral oil to counteract dryness (Pruritus of the external ear canal is a common problem. In most cases, the pruritus is self-induced from overenthusiastic cleaning or excoriation. The protective cerumen covering must be allowed to regenerate and may be helped to do so by application of a small amount of mineral oil, which helps counteract dryness and reject moisture. Often, the use of isopropyl alcohol may relieve ear canal pruritus as well)
• Avoid topical corticosteroids.

Jill, a 34-year-old bank teller, presents with symptoms of hay fever. She complains of nasal congestion, runny nose with clear mucus, and itchy nose and eyes. On physical assessment, you observe that she has pale nasal turbinates. What is your diagnosis?

• Allergic rhinitis (The symptoms of hay fever, also called allergic rhinitis, are similar to those of viral rhinitis but usually persist and are seasonal in nature. When assessing the nasal mucosa, you will observe that the turbinates are usually pale or violaceous because of venous engorgement)

A 75-year-old African American male presents to your family practice office complaining of visual impairment. He has worn corrective lenses for many years but has noticed that his vision has gotten progressively worse the past 6 months. He denies pain. He states his vision is worse in both eyes in the peripheral aspects of his visual field. He also notes trouble driving at night and halos around street lights at night. You test his intraocular pressure, and it is 23 mm Hg. What is his most likely diagnosis?

Open-angle glaucoma (This is the typical presentation of chronic, or open-angle, glaucoma)

What significant finding(s) in a 3-year-old child with otitis media with effusion would prompt more aggressive treatment and referral?

There is a change in the child's hearing threshold to greater than 25 dB (If a child with otitis media with effusion has a change in the hearing threshold greater than 25 dB and has notable speech and language delays, more aggressive treatment is indicated. When the child's hearing examination reveals a change in the hearing threshold, it is extremely important that the provider evaluate the child's achievement of developmental milestones in speech and language. Any abnormal findings warrant referral)

• The child has become a fussy eater.
• The child's speech and language skills seem slightly delayed.
• Persistent rhinitis is present.

In a young child, unilateral purulent rhinitis is most often caused by:

A foreign body (In a young child, unilateral purulent rhinitis is most often caused by a foreign body. The key word here is unilateral)

A viral infection (Viral infections usually affect both nares)

A bacterial infection (Bacterial infections usually affect both nares)

Allergic reaction (Allergic reactions usually affect both nares)

Marjorie, age 37, has asthma and has been told she has nasal polyps. What do you tell her about them?

• Nasal polyps are usually precancerous.

Nasal polyps are benign growths (Nasal polyps are benign growths that occur frequently in clients with sinus problems, asthma, and allergic rhinitis. Polyps are neither neoplastic growths nor precancerous, but they do have the potential to affect the flow of air through the nasal passages. Clients who have asthma and have nasal polyps may have an associated allergy to aspirin, a syndrome that is referred to as Samter triad.)

• The majority of nasal polyps are neoplastic.
• They are probably inflamed turbinates, not polyps, because polyps are infrequent in clients with asthma

Kevin, age 26, has AIDS and presents to the clinic with complaints of a painful tongue covered with what look like creamy white, curdlike patches overlying erythematous mucosa. You are able to scrape off these "curds" with a tongue depressor, which assists you in making which of the following diagnoses?

-Leukoplakia cannot be removed by rubbing the mucosal surface; it appears as little white
-Oral lichen planus is a chronic inflammatory autoimmune disease; it also has white lesions that do not rub off)
Oral candidiasis (Oral candidiasis (thrush) is distinctive because the white areas on the tongue can be rubbed off with a tongue depressor. Thrush may be seen in denture wearers, in debilitated clients, and in those who are immunocompromised or taking corticosteroids or broad-spectrum antibiotics)
Oral cancer must be ruled out in any lesion because early detection is the key to successful management and a good prognosis)

You diagnose 46-year-old Mabel with viral conjunctivitis. Your treatment should include:

Antibiotics should not be used in clients with viral conjunctivitis)
Antibiotics should not be used in clients with viral conjunctivitis)
Supportive measures and lubricating drops (artificial tears) (Viral conjunctivitis is treated with supportive measures, including cold compresses and lubricating eye drops. Preventive measures, such as frequent, are important, as viral conjunctivitis is highly contagious)
Antibiotics should not be used in clients with viral conjunctivitis)

The antibiotic of choice for recurrent acute otitis media (AOM) and/or treatment failure in children is:

Amoxicillin (Amoxil) is used as the first-line treatment of AOM. However, it is not used in patients with recurrent AOM or treatment failure)
Amoxicillin and potassium clavulanate (Augmentin) (The antibiotic of choice for recurrent AOM or treatment failure is amoxicillin and potassium clavulanate (Augmentin)

An 80-year-old woman comes in to the office with complaints of a rash on the left side of her face that is blistered and painful and accompanied by left-sided eye pain. The rash broke out 2 days ago, and she remembers being very tired and feeling feverish for a week before the rash appeared. On examination, the rash follows the trigeminal nerve on the left, and she has some scleral injection and tearing. You suspect herpes zoster ophthalmicus.
Based on what you know to be complications of this disease, you explain to her that she needs:
• Antibiotics.
• A biopsy of the rash.
• Immediate hospitalization.
Ophthalmological consultation (In this case, because the herpes virus seems to be along the ophthalmic branch of cranial nerve V, there is considerable risk that this client could develop permanent damage in that eye; therefore, an ophthalmological consult needs to be arranged promptly to ascertain current damage and prevent any further damage)

A 70-year-old client with herpes zoster has a vesicle on the tip of the nose. This may indicate:
• Ophthalmic zoster (herpes zoster ophthalmicus) involves the ciliary body and may appear clinically as vesicles on the tip of the nose. A client with a herpetic lesion on the nose needs to be referred to an ophthalmologist to preserve the eyesight.
• Herpes simplex primarily occurs on the perioral, labial, and genital areas of the body.
• Kaposi sarcoma in the older adult usually occurs in the lower extremities.
• Orf and milker's nodules almost always appear on the hands.

Dan, age 57, has just been given a diagnosis of herpes zoster. He asks you about exposure to others. You tell him:
• Once he has been on the medication for a full 24 hours, he is no longer contagious. Medication may shorten the course of the disease, but Dan should be instructed that before the rash crusts, it can release fluid that will cause an infection in others.
• He should stay away from children and pregnant women who have not had chickenpox. If a client has just been given a diagnosis of herpes zoster, advise the client to stay away from children and pregnant women who have not had chickenpox until crusts have formed over the blistered areas.
• He should wait until the rash is completely gone before going out in crowds. He does not have to wait until the rash is completely gone, just until crusts have formed.
• He should be isolated from all persons except his wife. Herpes zoster is contagious to people who have not had chickenpox, including his wife.

Mr. Swanson, age 67, presents to the clinic for his annual health exam. He asks you if there is anything he can do to prevent the painful, blistering sores that develop on his lip in the summertime when he plays golf. You explain to Mr. Swanson that the way to prevent the development of these lesions is to:
• Protect the lips from sun exposure with a blocking agent, such as zinc oxide, or a lip balm that contains a broad-spectrum sunscreen. Mr. Swanson has recurrent herpes simplex virus type 1 (HSV-1), ie, orolabial herpes. Factors that trigger reactivation include local skin trauma, sunlight exposure, and systemic changes, such as menses, fatigue, and fever. In this question, the clinician is teaching prevention. Protecting the lips from sun exposure is a preventive measure.
• Apply acyclovir 5% cream 5 times a day for 4 days. Application of topical antivirals or administration of oral antivirals is for the treatment of infection and is intended to reduce the healing time of primary and recurrent infections. It won't prevent further lesions.
• Take acyclovir 500 mg 1 tablet 5 times a day for 5 days. Application of topical antivirals or administration of oral antivirals is for the treatment of infection and is intended to reduce the healing time of primary and recurrent infections.
• Wear a visor. Wearing a wide-brimmed hat minimizes exposure to sunlight but may not provide adequate coverage of the lower face and lips.

Elizabeth, age 83, presents with a 2-day history of pain and burning in the left forehead. This morning she noticed a rash with erythematous papules at that site. What do you suspect?

• Varicella.

Although herpes zoster is caused by the reactivation of latent varicella virus in the distribution of the affected nerve, varicella (chickenpox) presents with a scattered rash on both sides of the body.

• Syphilis. A client with syphilis would present with sharply circumscribed, ham-colored papules with slight scale and lesions over the entire body, especially on the palms and soles.

• Rubella. Rubella (German measles) occurs in childhood. It begins on the face and rapidly (in hours) spreads down to the trunk.

• Herpes zoster. The rash of herpes zoster is distinctive, in that it appears on only one side of the body. Herpes zoster begins in a dermatomal distribution, most commonly in the thoracic, cervical, and lumbosacral areas, although it also occurs on the face. The classic presentation is when there is pain for 1-2 days preceding the eruption.

Which condition is not included in the atopic triad?

• Asthma

• Allergic Rhinitis

• Eczema

• Aspirin sensitivity This is included in the ASA, or Samter, triad, which also includes nasal polyps and asthma.

A 16-year-old male presents to your office. He was sent by an orthopedist. He has recently had surgical fixation of a humerus fracture. The patient has been going to physical therapy and has been developing a rash on his arm after therapy that disappears shortly after returning home. He does not have the rash prior to therapy. The patient denies fevers and chills, and his incision is well healed, with no signs of infection. Of note, the patient has been experiencing more hand edema than the average patient and has had edema wraps used at the end of therapy to help with his swelling. The wraps are made of a synthetic plastic material. The rash the patient gets is erythematous and blotchy, not raised; it is on the operative upper extremity. What is the most likely diagnosis?

• Contact dermatitis The patient's history and rash are consistent with a latex or plastic sensitivity due to the edema wraps used in therapy.

Atopic Dermatitis. The patient's rash is not consistent with eczema, which is dry and erythematous and usually found in the skin folds and around the eyes.

Sebhhoreic Dermatitis. The patient's rash is not consistent with seborrheic dermatitis, as no greasy yellow scales are present.

Psoriasis. Psoriasis is typically described as silvery scales on top of an erythematous, raised base.

Which of the following statements about malignant melanomas is true?

• They usually occur in older adult males. Malignant melanomas usually occur in middle-aged adults of both sexes.

• There will usually be no family history of melanoma. There will usually be a family history of melanoma.

• They are common in populations with dark skin. Melanomas occur rarely in dark-skinned populations; when they do, the lesions usually develop on the palms of the hands and the soles of the feet and under the nails.

• The prognosis is directly related to the thickness of the lesion.

The prognosis for a patient with a malignant melanoma is directly related to the thickness of the

lesion.

Lee brings her 13-year-old son to your clinic. He has been complaining of a rash on the buttocks, anterior thighs, and posterolateral aspects of his upper arms. He tells you it is mildly pruritic and looks like "gooseflesh." On examination, the rash appears as small, pinpoint, follicular papules on a mildly erythematous base. You explain to Lee that the benign condition is likely to resolve by the time her son reaches adulthood, and it is known as:

• Comedones of acne. The distribution of comedones of acne is on the face, chest, and upper back.

• Molluscum contagiosum. Molluscum contagiosum involves waxy-appearing lesions with a central umbilication.

• Keratosis pilaris. The description and examination of this rash are consistent with keratosis pilaris, which most commonly appears on the cheeks, buttocks, anterior thighs, and posterolateral aspects of the upper arms.

• Atopic dermatitis. Although it is characterized by a pruritic rash with dry, rough skin, atopic dermatitis in adolescents is more often located on extensor surfaces, the cheeks, and the hands.

Jim, age 59, presents with recurrent, sharply circumscribed red papules and plaques with powdery white scale on the extensor aspects of his elbows and knees. What do you suspect?

• Actinic keratosis. Actinic keratosis is distributed on sun-exposed areas, such as the face, head, neck, and dorsum of the hands, and appears as a poorly circumscribed, pink to red, slightly scaly lesion.

• Eczema. Eczema presents as a group of pinpoint pruritic vesicles and papules on a coin-shaped, erythematous base and usually worsens in winter.

• Psoriasis. If a client presents with recurrent, sharply circumscribed red papules and plaques with powdery white scale on the extensor aspects of his elbows and knees, suspect psoriasis. This is a classic presentation of psoriasis. Besides the extensor aspects of the elbows and knees, it occurs frequently in the presacral area and scalp, although lesions may occur anywhere.

• Seborrheic dermatitis. Seborrheic dermatitis often appears on the scalp. SX range from dry flakes to yellow, greasy scales with reddened skin. It may also occur on other oily areas such as the face, upper chest and back.

Which of the following statements about psoriasis is not true?

Psoriatic lesions are often silvery scales that form over erythematous plaques. This is a general description of psoriasis.

• Psoriatic lesions often occur in the folds of the elbows and behind the knees. This is untrue; lesions usually occur on the fronts of the knees, the posterior aspects of the elbows, and the

People with psoriasis have a greater risk of depression than the average population. This is true; there is a correlation between psoriasis and an increased risk of developing depression.

Psoriasis has a genetic component.

This is true; psoriasis has a genetic component and is associated with genetic findings on chromosomes 4, 6, 8, 16, and 17.

Which presentation is most concerning for skin cancer?

• Dark pigmentation of 1 solitary nail that has developed quickly and without trauma. This is concerning for acral melanoma

• A 1-mm blue, round, nonpalpable discoloration of the skin that has been present since birth without change. This describes a benign blue nevus, common in patients of Asian descent.

A 5-mm black mole with round, regular boarders.

This mole is round, regular, less than 6 mm, and without change; it is likely benign.

• A 2-mm brown mole that is raised 1 mm but round and regular. This mole is small, regular, minimally raised, and only 1 color; it is likely benign.

A 4-year-old male presents to your pediatric clinic with his mother complaining of an itchy rash, mostly between his fingers. This has been going on for multiple days and has been getting worse. The patient recently started at a new day care. On physical exam, the patient is afebrile and has multiple small (1-2 mm) red papules in sets of 3 located in the web spaces between his fingers. He also has signs of excoriation. What is the treatment for this problem?

• Permethrin lotion for the patient and also his family members. – This is the treatment for scabies

Cold compresses and hydrocortisone cream 1% twice a day. - This would decrease inflammation but would not cure the scabies.

Over-the-counter Benadryl cream. This would provide itching relief but would not cure the scabies.

Ketoconazole cream. This would treat a fungal infection, not scabies.

Which of the following patients would not be at risk of Candida infection?

• A patient with a history of coronary artery disease. Coronary artery disease doesn't increase the risk of Candida infection.

A diabetic patient. Diabetes increases the risk of Candida infection.

• A patient requiring home antibiotics while recovering from an operation for an infected hernia. Use of long-term antibiotics increases the risk of Candida infection.

A patient using a steroid regimen for asthma control Use of long-term steroids increases the risk of Candida infection.

A 3-year-old patient presents to your pediatric office with her mother. She has recently been started in day care. Her mother noted slight perioral erythema on the right side of the patient's mouth prior to bed last night. The patient awoke today with 3 small, superficial, honey-colored vesicles where the erythema was last night. The patient has no surrounding erythema. She had no difficulty eating this morning and is active and energetic and doesn't appear lethargic or fatigued. She is also afebrile. How would you treat this child?

• Local debridement and mupirocin for 5 days. This is the treatment of choice for impetigo.

Oral Keflex for 7 days. This is for more severe cases in which the patient is febrile.

Topical compress with Burow solution and follow-up in 2 to 3 days. This compress would help but would not prevent bacterial spread.

Local debridement and topical compress with Burow solution and close follow-up. This would help as well but wouldn't prevent bacterial spread.

A 22-year-old college student presents to your urgent care clinic complaining of a rash. She was recently on spring break and spent every night in the hot tub at her hotel. On physical exam, she has multiple small areas of 1- to 2-mm erythematous pustules that are present mostly where her bathing suit covered her buttocks. What is the most likely pathogen causing these lesions?

• Pseudomonas aeruginosa. This is a common cause of hot tub folliculitis.

Klebsiella. This could be a cause of folliculitis in an immunocompromised patient.

Staphylococcus aureus. Gram-positive bacteria can cause folliculitis, but this is not the most common pathogen found in a hot tub.

Streptococcus. Gram-positive bacteria can cause folliculitis, but this is not the most common pathogen found in a hot tub.

A 10-year-old male in 5th grade presents to the pediatric office with his mother complaining of itchy and red eyes for 1 day. The patient complains of watery drainage in both eyes, associated with repetitive itching. On physical exam, he has no fever or constitutional symptoms. His vision is normal, with no decrease in extraocular movements. The patient has a sibling that just started day care recently. He also has bilateral preauricular lymph nodes that are inflamed. What is the patient's diagnosis?
Viral conjunctivitis (This is the classic presentation of viral conjunctivitis. The patient also has exposure to kids at school and a sibling with day care exposure)
-Bacterial conjunctivitis.
-Allergic conjunctivitis.
-Blepharitis.
Justin, an obese 42-year-old, cut his right leg 3 days ago while climbing a ladder. Today his right lower leg is warm, reddened, and painful, without a sharply demarcated border. What do you suspect?
• Diabetic neuropathy. Although Justin may have diabetic neuropathy, the information is not complete enough for you to suspect that condition.
• Peripheral vascular disease. Although Justin may have peripheral vascular disease, the information is not complete enough for you to suspect that condition.
• A beginning stasis ulcer. Although Justin may have a stasis ulcer, the information is not complete enough for you to suspect that condition.
Cellulitis. Cellulitis is a spreading infection of the epidermis and subcutaneous tissue that usually begins after a break in the skin. The skin of this patient's right lower leg is warm, red, and painful. Although Justin may have diabetic neuropathy, peripheral vascular disease, or a stasis ulcer, the information is not complete enough for you to suspect those conditions. The information and assessment data given fully support a diagnosis of cellulitis.

Danny, age 18, presents with a pruritic rash on his upper trunk and shoulders. You observe flat to slightly elevated brown papules and plaques that scale when they are rubbed. You also note areas of hypopigmentation. What is your initial diagnosis?
• Lentigo syndrome. Lentigines are macular tan to black lesions ranging from 1 mm to 1 cm in size. They do not increase in color with exposure to the sun. One or more lentigines are seen in normal individuals. Multiple ones need to be further assessed.
• Tinea versicolor. If a client presents with a pruritic rash on his upper trunk and shoulders and you observe areas of hypopigmentation and flat to slightly elevated brown papules and plaques that scale when they are rubbed, suspect tinea versicolor.
• Localized brown macules. Localized brown macules are freckles.
• Ochronosis. Ochronosis is a condition with poorly circumscribed blue-black macules.

Buddy, age 13, presents with annular lesions with scaly borders and central clearing on his trunk. What do you suspect?
• Psoriasis. Psoriasis has annular lesions on the elbows, knees, scalp, and nails.
• Erythema multiforme. Erythema multiforme has annular lesions that are mostly acral in distribution and are often associated with a recent herpes simplex infection.
• Tinea corporis. Psoriasis, erythema multiforme, tinea corporis, and syphilis all have lesions with annular configurations. Tinea corporis (ringworm) has ring-shaped lesions with scaly borders and central clearing or scaly patches with distinct borders on exposed skin surfaces or on the trunk.
• Syphilis. Secondary syphilis lesions are usually on the palmar, plantar, and mucous membrane surfaces.

You're teaching Mitch, age 18, about his tinea pedis. You know he doesn't understand your directions when he tells you which of the following?
• "I should dry between my toes every day. Clients with tinea pedis should dry between the toes every day.
• "I should wash my socks with bleach." Clients with tinea pedis should wash socks with bleach.
• "I should use an antifungal powder twice a day." Clients with tinea pedis should use an antifungal powder twice per day. Antifungal powders or sprays are preferred over creams, as fungi thrive in warm, moist environments.
• "I should wear rubber shoes in the shower to prevent transmission to others." Rubber- or plastic-soled shoes can harbor the fungus and therefore should not be worn. The shower should be washed with bleach to kill the fungi.

Thomas, age 35, uses a high-potency corticosteroid cream for a dermatosis. He also currently has tinea corporis. You tell him the following regarding the cream:
• "You must use this for an extended period of time for it to be effective." Topical corticosteroids should not be used for an extended period of time.
• "It will work better if you occlude the area." The area should not be occluded.
• "It may exacerbate your concurrent tinea corporis." If a client uses a high-potency corticosteroid cream for a dermatosis, tell the client that it may exacerbate concurrent conditions such as tinea corporis and acne. Topical corticosteroids should not be used indiscriminately on all cutaneous eruptions.
• "Be sure to use it daily." Intermittent therapy with high-potency agents, such as every other day, or 3 to 4 consecutive days per week, may be more effective and cause fewer adverse effects than continuous regimens. This is also true of lower potency corticosteroids.

Jill, age 29, has numerous transient lesions that come and go, and she is diagnosed with urticaria. What do you order?
• Aspirin is to be avoided.
• Ibuprofen is to be avoided.
• Opioids are to be avoided.
• Antihistamines Transient urticaria requires antihistamines on a regular basis

Martin, age 13, just started taking amoxicillin for otitis media. His mother said that he woke up this morning with a rash on his trunk. What is your first action?
• Prescribe systemic antihistamines Symptomatic relief may be obtained with systemic antihistamines.
• Prescribe a short course of systemic steroids. Systemic steroids may be necessary with severely symptomatic clients, although topical steroids may help clients with pruritus.

• Stop the amoxicillin. If you suspect a drug reaction to amoxicillin, stop the amoxicillin.
• Continue the drug; having this reaction early in the course is normal. This reaction is not normal. If the patient is allergic to penicillin, treatment should be discontinued.

Sandra, age 69, is complaining of dry skin. What do you advise her to do?
Bathe or shower with lukewarm water and use a mild soap or skin cleanser. If a client is complaining of dry skin, the client should use tepid water and a mild cleansing cream or soap.

Sandy asks what she can do for Dolores, her 90-year-old mother, who takes a bath every day and who has extremely dry skin. You respond:
• "After bathing every day, use a generous amount of moisturizer." Applying a moisturizing cream will help the general problem.
• "Use a special moisturizing soap every day." Plain water should be used rather than special soap.
• "Increase your mother's intake of fluids." Increasing fluids will help but bathing every other day
• "Your mother does not need a bath every day." Dolores does not need a bath every day because that will exacerbate the dryness of her skin.
will help more.

Candidiasis may occur in many parts of the body. James, age 29, has it in the glans of his penis. What is your diagnosis?
• Balanitis. Candidiasis of the glans of the penis is balanitis.
• Thrush. Thrush is oral candidiasis.
• Candidal paronychia. Candidal paronychia involves the tissue surrounding the nail.
• Subungual Candida. Subungual Candida is candidiasis under the nail.

Cataracts are a common occurrence in patients over 60 years of age. You counsel your patient that the best cure for cataracts is:
• Dietary supplements.
Corrective lens surgery (To date, no pharmaceutical treatment proven to delay, prevent, or reverse the development of cataracts exists. The definitive management for a cataract is a surgical approach, one that removes the defective lens and replaces it with an artificial one)
• Optical devices.

A 62-year-old woman presents to your clinic with a sudden right-sided headache that is worse in her right eye. She states that her vision seems blurred, and her right pupil is dilated and slow to react. The right conjunctiva is markedly injected, and the eyeball is firm. You screen her vision and find that she is 20/30 OS and 20/30 OD. She most likely has:
• Open-angle glaucoma (With open-angle glaucoma, the onset is more insidious)
• Herpetic conjunctivitis (Herpetic conjunctivitis is generally associated with a herpetic rash, and the pain is dull in character)
• Diabetic retinopathy (Diabetic retinopathy is a complication of diabetes that affects both eyes. It is caused by damage to the blood vessels of the light-sensitive tissue at the back of the eye (ie, the retina)
Angle-closure glaucoma (In angle-closure glaucoma, the patient presents with a sudden onset of symptoms as described in this case. This client has a visual deficit and pain as well as fullness of the affected eye. This is a medical emergency, and she should be referred immediately because, without intervention, blindness can occur within days)

Alexandra, age 34, was treated with oral antibiotics 2 weeks ago for a urinary tract infection. She is seen in the office today for a follow-up visit. On physical examination, the nurse practitioner notices that she has some painless, white, slightly raised patches in her mouth. This is probably caused by:
Herpes simplex (a viral infection) sores are usually discrete and not spread over a large
• Herpes simplex (area)
• Aphthous ulcers (Aphthous ulcers (canker sores) are extremely painful)
Candidiasis (Painless, white, slightly raised patches in a client's mouth are probably caused by candidiasis(thrush)
Oral cancer. Cancerous lesions are usually discrete and not spread over a large area)

You are teaching Harvey, age 55, about the warts on his hands. What is included in your teaching?
• Treatment is usually effective, and most warts will not recur afterward. Despite treatment, most warts recur.
• Because warts have roots, it is difficult to remove them surgically. Contrary to popular opinion, warts do not have roots; the underside of a wart is smooth and round.
• Shaving the wart may prevent its recurrence. Abrading the skin can spread the virus; vigorous rubbing, shaving, and nail biting, can do the same.
• Warts are caused by the human papillomavirus. Warts are caused by the human papillomavirus. One in four people is infected with this virus, and most warts recur despite treatment.

Which of the following should be used with all acne medications?
• Sunscreen Sunscreen should be used with all acne medications.
• Oily makeup Oily makeup and oily hair conditioners or scalp products should be avoided.
• Plain Soap The face should be washed gently at least twice per day with an antibacterial soap.
• A light alcohol wipe once a week Alcohol wipes can cause excessive skin dryness.

A 55-year-old landscaper presents to your primary care office complaining of a small skin lesion on his face. The patient states the lesion causes no pain or other symptoms. On physical exam, you notice a small (3 mm) papule that is flesh-colored and irregular. To palpation, the lesion feels hard and like sandpaper. What type of malignancy is this patient at risk for given the appearance of this lesion?
• Squamous Cell Carcinoma. The lesion described is an actinic keratosis, which is a premalignant lesion that can progress to squamous cell carcinoma.
Melanoma. Melanoma is a type of cancer that arises in melanin-forming cells; the lesion described here is not melanoma.
Basal Cell Carcinoma. Basal cell carcinoma typically presents as a papular lesion with
• Rosacea is not associated with cancer.

Your 24-year-old client whose varicella rash just erupted yesterday asks you when she can go back to work. What do you tell her?
• "Once all the vesicles are crusted over." A client who has a varicella rash can return to work once all the vesicles are crusted over. Varicella is contagious 48 hours before the onset of the vesicular rash, during the rash formation (usually 4-5 days), and during the several days it takes the vesicles to dry up. The characteristic rash appears 2 to 3 weeks after exposure.
• "When the rash is entirely gone." A client who has a varicella rash can return to work once all the vesicles are crusted over.
• "Once you have been on medication for at least forty-eight hours." Treatment is effective only if started within the first few days and then only to shorten the course of the disease.
• "Now, as long as you stay away from children and pregnant women."

Clients should avoid contact with pregnant women and children who have not been exposed to varicella.

Client teaching is an integral part of successfully treating pediculosis. Which of the following statements would you incorporate into your teaching plan?
• "It's okay to resume sharing combs, headsets, and so on after being lice-free for one month." Clients and parents should be instructed not to share hats, combs, scarves, headsets, towels, and bedding.
• "Soak your combs and brushes in rubbing alcohol for eight hours." Combs and brushes should be soaked in rubbing alcohol for 1 hour.
• "Itching may continue for up to a week after successful treatment." Client education is essential when treating pediculosis. Clients should be informed that itching may continue for up to a week after successful treatment because of the slow resolution of the inflammatory reaction caused by the lice infestation.
• "Spraying of pesticides in the immediate environment is essential to prevent recurrence." Excessive decontamination of the environment is not necessary. Environmental spraying of pesticides is not effective and, therefore, is not recommended. Bedclothes and clothing should be washed in hot, soapy water.

Tom, age 50, is complaining of an itchy rash that occurred about a half hour after putting on his leather jacket. He recalls having a slightly similar rash last year when he wore his jacket. The annular lesions are on his neck and both arms. They are erythematous, sharply circumscribed, and both flat and elevated. His voice seems a little raspy, although he states that his breathing is normal. What is your first action?
• Order a short course of systemic corticosteroids. All the actions are appropriate. However, it is most important to determine if respiratory distress is imminent; if it is, epinephrine must be administered.
• Determine the need for 0.5 mL 1:1000 epinephrine subcutaneously. Tom has hives. Although all the actions are appropriate, the first step is to determine the need for 0.5 mL 1:1000 epinephrine subcutaneously. With Tom's neck involvement, it is most important to determine if respiratory distress is imminent; if it is, epinephrine must be administered.
• Start daily antihistamines. All the actions are appropriate. However, it is most important to determine if respiratory distress is imminent; if it is, epinephrine must be administered.
• Tell Tom to get rid of his leather jacket. All the actions are appropriate. However, it is most important to determine if respiratory distress is imminent; if it is, epinephrine must be administered.

When palpating the skin over the clavicle of Norman, age 84, you notice tenting, which is:
• Indicative of dehydration Skin turgor is decreased with dehydration. • Common in thin older adults Tenting—which occurs when pinched skin remains pinched for a few moments before resuming its normal position—over the clavicle is common in thin older adults. Skin turgor is decreased with dehydration and increased with edema and scleroderma.
• A sign of edema Skin turgor is increased with edema.
• Indicative of scleroderma Skin turgor is increased with scleroderma

Which disease usually starts on the cheeks and spreads to the arms and trunk?
• Erythema infectiosum (fifth disease) usually starts on the cheeks and spreads to the arms and trunk.
• Rocky Mountain spotted fever, which is associated with a history of tick bites, starts as a maculopapular rash with erythematous borders, appearing first on the wrists, ankles, palms, soles, and forearms.
• Rubeola (measles) starts as a brownish-pink maculopapular rash around the ears, face, and neck, and then progresses over the trunk and limbs.
• Rubella (German measles) starts as a fine, pinkish, macular rash that becomes confluent and pinpoint after 24 hours.

A 27-year-old female comes in to your primary care office complaining of a perioral rash. The patient noticed burning around her lips a couple days ago that quickly went away. She awoke from sleep yesterday and noticed a group of vesicles with erythematous bases where the burning had been before. There is no burning today. She is afebrile and has no difficulty eating or swallowing. What test would confirm her diagnosis?
• Tzanck smear. This would show giant cells consistent with herpes simplex virus.
Potassium hydroxide (KOH) prep. This is used to diagnose fungal infections.
Exam under a Wood lamp.
This is used to diagnose fungal infections.
Sterile culture sent for aerobic and anaerobic bacteria. This would help with bacterial causes of these lesions; a polymerase chain reaction (PCR) would have to be sent to diagnose herpes simplex.

Caroline has a 13-year-old daughter who has had 2 recent infestations of lice. She asks you what she can do to prevent this. You respond:
• "After two days of no head lice, her bedding is lice-free." Lice can survive for more than 2 days off the scalp, so they could still be alive in the bed linen after 2 days.
• "Boys are more susceptible, so watch out for her brother also." Girls are more susceptible than boys.
• "After several infestations, she is now immune and is no longer susceptible." Immunity against head lice is never acquired.
• "Don't let her share hats, combs, or brushes with anyone." Head lice may be transmitted by sharing hats, combs, or brushes, so these practices should be discouraged.

Sharon, a 47-year-old bank teller, is seen by the nurse practitioner in the office for a red eye. You are trying to decide between a diagnosis of conjunctivitis and iritis. One distinguishing characteristic between the two is:
Clients with iritis and those with conjunctivitis both complain of eye discomfort, although in iritis the pain is moderately severe, with intermittent stabbing)
Both conditions generally produce a slowly progressive redness.
• A ciliary flush (When trying to decide between a diagnosis of conjunctivitis and iritis, one distinguishing characteristic is the ciliary flush present in iritis. Photophobia is not usually present in conjunctivitis, but itis always present with iritis. Photophobia occurs with corneal inflammation, iritis, and angle-closure
glaucoma)
Vision is normal with conjunctivitis and blurred with iritis)

Susan is a 19-year-old college student and avid swimmer. She frequently gets swimmer's ear and asks if there is anything she can do to help prevent it other than wearing earplugs, which do not really work for her. What do you suggest?

- Start using a cotton-tipped applicator to dry the ears after swimming.
- Use ear drops made of a solution of equal parts alcohol and vinegar in each ear after swimming (Using ear drops made of a solution of equal parts alcohol and vinegar in each ear after swimming is effective in drying the ear canal and maintaining an acidic environment, therefore preventing a favorable medium for the growth of bacteria, the cause of swimmer's ear)
- Use a hair dryer on the highest setting to dry the ears.
- Stop swimming

Mary, age 82, presents with several eye problems. She states that her eyes are always dry and look "sunken in."

What do you suspect?

Normal Age related

What is the most common bacterial pathogen associated with acute otitis media?

Streptococcus pneumonia (This causes 40% to 50% of cases)

H. Influenza (This causes 10% to 30% of cases)

- Streptococcus pyogenes (this is an uncommon cause)
- Moraxella (Branhamella) catarrhalis (This is an uncommon cause)

You diagnose acute epiglottitis in Sally, age 5, and immediately send her to the local emergency room. Which ofthe following symptoms would indicate that an airway obstruction is imminent?

- Reddened face.
- Screaming.
- Grabbing her throat.
- Stridor (In a pediatric client with acute epiglottitis, a number of symptoms can indicate that airway obstruction is imminent: stridor, restlessness, nasal flaring, as well as the use of accessory muscles of respiration)

Mrs. Johnson, a 54-year-old accountant, presents to the office with a painful red eye without discharge. You should suspect

- Bacterial conjunctivitis (With bacterial conjunctivitis, there is purulent, thick discharge)
- Viral conjunctivitis (With viral conjunctivitis, there is usually a watery discharge)
- Allergic conjunctivitis (With allergic conjunctivitis, there is a stringy, mucoid discharge)

Iritis (In a client with iritis, there is rarely a discharge)