NR 509 APEA 3P EXAM WEEK 4 2024 LATEST QUESTIONS AND GUARANTEED CORRECT ANSWERS WITH RATIONALES ALREADY GRADED A+.

A 73-year-old retired salesman presents to the Emergency Department complaining of chest pain that started about 2 hours ago. Electrocardiogram, cardiac enzymes, and chest x-ray are normal. The nurse notes that his blood pressures in the right arm are significantly lower than of blood pressures in his left arm. Based on history and physical examination, which of the following will most likely explain his signs and symptoms? - ANSWER- a. Dissecting aortic aneurysm

Rationale: Patients with dissecting aortic aneurysms typically present with chest pain, many times described as a "tearing" type pain. They are usually elderly, and, due to the dissection of the aorta, asymmetric pulses in blood pressures in the extremities may be present. Coarctation of the aorta can also cause similar symptoms; however, it would be unlikely due to the patient's age as this is a congenital defect. MI, PE, and pericarditis are also common causes of concerning chest pain; however, neither typically will cause asymmetric blood pressures or pulses in the extremities.

A 19-year-old carwash attendant sustained a laceration to the ulnar aspect of his mid-forearm while at work last week. He did not have it evaluated at that time and is now noticing purulent discharge and increasing pain from the wound along with fever and chills. Where would the clinician expect to find the first signs of lymphadenopathy? - ANSWER- a. Epitrochlear nodes

Rationale: The epitrochlear nodes are the first nodes in the drainage region from the ulnar surface of the forearm and hand, little and ring fingers, and adjacent surface of the middle finger. Axillary nodes, infraclavicular nodes, and cervical chain nodes are all distal to this area and may show evidence of lymphadenopathy as well; however, that would be secondary after the epitrochlear nodes.

When assessing for the femoral pulse, where should the clinician begin deeply palpating? - ANSWER- C. Below the inguinal ligament, midway between the anterior superior iliac spine and symphysis pubis

Rationale: The clinician would begin deeply palpating below the inguinal ligament, midway between the anterior superior iliac spine in the symphysis pubis. The external iliac artery transitions into the femoral artery at the level of the inguinal ligament. Therefore, palpating above the inguinal ligament would be assessing the external iliac artery. The femoral artery is typically located midway between the anterior superior iliac spine in the symphysis pubis in most patients.

The clinician is palpating pulses in the foot of a diabetic patient while in the clinic. A strong pulse is felt located on the dorsum of the foot, just lateral to the extensor tendon of the big toe. Which artery is being assessed? - ANSWER- C. Dorsalis pedis

Rationale: The dorsalis pedis artery is usually palpable on the dorsum of the foot just lateral to the extensor tendon of the big toe. The arterial arch of the foot is more distal and runs transversely and is not usually palpable. The posterior tibial artery is found

behind the medial malleolus of the ankle. The popliteal and femoral pulses are found more proximally at the knee and near the groin, respectively.

A 68-year-old retired administrative assistant complains of a 3-month history of recurring pain after ambulating that radiates from her back in the upper lumbar region into both buttocks, bilateral thighs, and mid-calf regions. Her pain is typically improved by sitting or by leaning forward. The origin of her pain is likely secondary to which of the following? - ANSWER- d. Neurogenic claudication

Rationale: Neurogenic claudication can mimic PAD by causing pain related to walking; however, it is typically relieved simply by sitting or by leaning forward. Many patients with spinal stenosis of the lumbar spine have pain that originates in the spinal region and radiates into the areas noted. PAD is not typically relieved just by sitting alone and usually will take some time. PAD also does not typically improve with bending over. Acute arterial occlusion does not cause recurring symptoms and is not usually bilateral. Abdominal aortic aneurysms may cause similar pain as well; however, they typically do not have the same palliating factors.

A patient that has a known history of cardiovascular disease including a myocardial infarction and positive ankle-brachial index indicating peripheral arterial disease in his left leg is now having some issues with erectile dysfunction (ED). The clinician suspects it may be due to medications or further vascular disease. He does not complain of any other symptoms. If his symptoms are related to vascular disease, where would the lesion likely be located? - ANSWER- b. Iliac pudendal

A 61-year-old retired librarian was recently diagnosed with ovarian cancer. She was otherwise healthy until her recent cancer diagnosis. She has not been feeling well lately and has had a cough and some mild shortness of breath for the past couple of days. She now presents to the clinic complaining of pain and swelling in her right groin and leg, which she says is been there for about a week but is worsening. On physical examination, 2+ edema of the right leg up to the thigh; 1+ femoral, popliteal, dorsalis pedis, and posterior tibial pulses; and no significant erythema are noted. What is the chief concern with this patient? - ANSWER- d. Pulmonary embolism (PE)
Rationale: Cancer patients are at high risk of deep venous thrombosis (DVT), and, with the presenting symptoms of swelling and pain in her groin, along with recent history of cough and shortness of breath, this patient's presentation is suspicious for PE. Patients with DVT in the proximal leg veins are at high risk of thromboembolism. Acute arterial occlusion should not cause significant edema, and pulses would likely be absent. The constellation of symptoms and history in this patient also does not suggest an acute arterial occlusion. Superficial thrombophlebitis typically only causes mild local swelling, redness, and warmth along with a subcutaneous cord. Acute lymphangitis typically presents with red streaks from an infection passing through lymph channels.

A 32-year-old cabdriver complains of pain in his left leg. He has a history of type 2 diabetes, is a smoker, and recently was diagnosed with hypertension. He does not remember injuring his leg; however, he notes that there is a small wound on the lateral