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Question: 1712

A patient with a sacral pressure injury is on continuous enteral feeding and develops diarrhea that soaks the wound dressing. Which of these management strategies directly improves pressure injury healing success?

A. Apply zinc oxide paste only without stool diversion methods
B. Decrease enteral feeding rate to minimize diarrhea frequency
C. Implement a fecal management system to protect periwound skin from moisture
D. Use dry gauze dressings that wick away moisture better than foam

Answer: C

Explanation: A fecal management system effectively diverts stool away from the skin, reducing moisture and bacterial exposure, which are key factors in wound healing failure. Simply reducing feeding or applying barrier creams alone are insufficient. Dry gauze does not maintain a moist wound environment needed for healing.

Question: 1713

During transport of a postoperative patient requiring continuous capnography (ETCO2) monitoring, which alarm parameter change requires immediate intervention?

A. Respiratory rate increase from 16 to 18 breaths per minute
B. ETCO2 level dropping to 25 mmHg from baseline 38 mmHg
C. Pulse oximetry reading equal to ETCO2 value
D. Stable ETCO2 at 35 mmHg with occasional waveform fluctuations

Answer: B

Explanation: A significant drop in ETCO2 indicates possible hypoventilation, disconnection, or pulmonary embolism and requires urgent assessment and intervention during transport. Minor respiratory rate increase and waveform fluctuations may be less critical.

Question: 1714

Which of the following best describes the pathophysiological abnormality in pleural effusion?

A. Pulmonary artery obstruction causing infarction
B. Direct alveolar injury causing air leak into the pleural space
C. Bronchial obstruction causing distal lung collapse
D. Increased hydrostatic pressure or decreased oncotic pressure causing fluid accumulation

Answer: D

Explanation: Pleural effusions result from imbalance between hydrostatic and oncotic pressures or pleural capillary permeability changes leading to fluid accumulation in the pleural space. Air leak describes pneumothorax; bronchial obstruction causes atelectasis; artery obstruction causes infarction.

Question: 1715

An ICU patient with severe diarrhea has these labs: Na+ 128 mEq/L, K+ 3.1 mEq/L, Cl- 90 mEq/L. What acid-base disorder is most likely present?

A. Respiratory acidosis
B. Metabolic alkalosis with respiratory compensation
C. Metabolic acidosis with respiratory compensation
D. Respiratory alkalosis

Answer: C

Explanation: Electrolyte losses cause metabolic acidosis and the respiratory system compensates by hyperventilating lowering PaCO2.

Question: 1716

A patient with thrombocytopenia shows a platelet count decrease from 220,000 to 70,000/mm³ five days after heparin therapy. Serotonin release assay is positive. Which treatment is most appropriate?

A. Continue heparin and add aspirin
B. Discontinue heparin and start argatroban
C. Administer platelet transfusion immediately
D. Start warfarin and monitor INR

Answer: B

Explanation: This is heparin-induced thrombocytopenia (HIT), an immune-mediated platelet activation disorder. The immediate step is to stop all heparin products and begin a direct thrombin inhibitor (e.g., argatroban). Platelet transfusions are usually avoided due to thrombotic risk. Warfarin is started only after platelet recovery.

Question: 1717

A 60-year-old with NSAID-induced AKI (creatinine 4.0 mg/dL, muddy brown casts) requires

intermittent hemodialysis. Pre-dialysis potassium 6.8 mEq/L, post-dialysis 3.9 mEq/L. Formula for potassium removal = (pre-K - post-K) × TBW × 0.6 yields 120 mEq/session. Rebound hyperkalemia occurs 4 hours later (5.6 mEq/L). Which comorbid agent, continued for gout, synergistically impairs distal potassium secretion and necessitates discontinuation?

A. Probenecid 500 mg twice daily
B. Colchicine 0.6 mg daily
C. Febuxostat 80 mg daily
D. Allopurinol 300 mg daily

Answer: A

Explanation: Probenecid inhibits organic anion transporters, reducing NSAID clearance and impairing distal tubule function, exacerbating hyperkalemia rebound by blocking aldosterone-sensitive potassium secretion; 2024 consensus on nephrotoxins flags uricosurics in AKI. Discontinue, use allopurinol alternative. Colchicine risks myopathy, febuxostat minimal renal effect.

Question: 1718

A 45-year-old patient arrives with a sudden onset of weakness in the right arm and leg, slurred speech, and confusion. CT scan shows a left middle cerebral artery ischemic stroke. Which of the following lab values is most critical to monitor before administering tissue plasminogen activator (tPA)?

A. White blood cell count of 12,000/mm³
B. Platelet count of 150,000/mm³
C. Serum glucose of 70 mg/dL
D. International normalized ratio (INR) of 2.0

Answer: D

Explanation: Prior to administering tPA in ischemic stroke, it is essential to confirm coagulation status. An INR of 2.0 indicates an increased bleeding risk and is a contraindication for tPA due to the elevated risk of hemorrhage. Platelet count at 150,000/mm³ is within normal limits. Serum glucose of 70 mg/dL is low but not a contraindication, although glucose should be normal or corrected. Elevated WBC indicates possible infection but is not critical for tPA decision.

Question: 1719

A patient has developed an IV extravasation injury after infusion of dopamine hydrochloride at 20 mcg/kg/min. The site shows swelling, pain, and pallor. What is the best next step in managing this infiltration?

A. Inject hyaluronidase around the infiltration site to dilute the dopamine
B. Continue the infusion at a lower dose to prevent vasospasm progression
C. Apply warm compresses and start systemic vasodilators immediately
D. Stop the infusion, aspirate residual drug from the catheter, and elevate the limb

Answer: D

Explanation: Dopamine at high doses can cause vasoconstriction, and infiltration requires stopping the infusion immediately, attempting to aspirate residual drug to reduce local toxicity, and elevating the limb. Warm compresses are generally appropriate for non-vesicant infiltrations, but dopamine requires caution. Hyaluronidase is typically used for infiltration of certain agents like vinca alkaloids, but its role with dopamine is limited.

Question: 1720

Which finding in a postoperative patient indicates a potential early emergency requiring urgent intervention?

A. Heart rate of 105/min with systolic BP of 110 mmHg
B. Oxygen saturation dropping from 96% to 88% on 3L nasal cannula
C. Mild nausea after opioid administration
D. Patient reporting mild incisional discomfort

Answer: B

Explanation: A significant drop in oxygen saturation suggests respiratory compromise and warrants immediate evaluation and intervention. Elevated heart rate with stable BP is less urgent. Mild nausea and incisional discomfort are expected postoperative findings.

Question: 1721

A 55-year-old with rib fractures/flail has epidural catheter. Contusion worsens (ground-glass on CT). ECMO considered if P/F <80. Calculate shunt fraction (Qs/Qt = [CcO2 - CaO2]/[CcO2 - CvO2]; CcO2 20 vol%, CaO2 15 vol%, CvO2 10 vol%) =0.33 (shunt 33%). Threshold for VV-ECMO?

A. Shunt >30%
B. P/F <80
C. Dead space >40%
D. Both A and B

Answer: D

Explanation: Trauma ARDS from contusion; high shunt indicates refractory hypoxemia. VV-ECMO for P/F <80 + shunt >30% unresponsive to ventilation/prone.

Question: 1722

A 38-year-old female at 39 weeks with group B Streptococcus colonization receives intrapartum penicillin. Post-delivery, she develops fever 39°C, uterine tenderness, and foul lochia. Labs: WBC 20,000/mm³, CRP 150 mg/L, blood cultures positive for E. coli and GBS. The nurse suspects

polymicrobial endometritis. Vacuum extraction complicated by cervical laceration repaired. What broad-spectrum regimen covers anaerobes per ACOG 2022 postpartum infection guidelines?

A. Vancomycin 15 mg/kg q12h plus piperacillin-tazobactam 3.375g q6h
B. Ampicillin 2g IV q6h plus azithromycin 500 mg IV daily
C. Ceftriaxone 1g IV daily monotherapy
D. Clindamycin 900 mg IV q8h plus gentamicin 5 mg/kg/day

Answer: D

Explanation: Postpartum endometritis (cesarean risk higher) polymicrobial (GBS, E. coli, anaerobes); clindamycin + gentamicin first-line per guidelines, effective against beta-lactamase producers. Ampicillin/azithro for chorio; ceftriaxone insufficient anaerobes; vanco/PIP-TAZ for MRSA/MDR but not routine.

Question: 1723

A 38-year-old female with central DI post-TBI has sodium 155 mEq/L on desmopressin q12h. She spikes to 162 mEq/L mid-dose. What pharmacokinetic adjustment?

A. Switch to subcutaneous 10 mcg q12h
B. Increase dose to 4 mcg IV q6h
C. Add chlorpropamide to potentiate
D. Fluid match urine output 1:1

Answer: B

Explanation: Desmopressin half-life ~2-3 hours; breakthrough hypernatremia indicates short duration post-TBI. Frequent dosing (q6-8h IV) maintains aquaporin activation. SubQ alternative but IV precise in ICU; chlorpropamide outdated; matching risks volume overload.

Question: 1724

A patient with an ostomy has developed skin irritation and maceration around the stoma site. The nurse suspects leakage of effluent as causative. What is the priority nursing intervention to protect skin integrity?

A. Increase frequency of pouch emptying to every hour and cleanse with soap and water
B. Optimize ostomy pouching system fit and use skin barrier seals around the stoma
C. Apply topical corticosteroids to reduce inflammation and irritation
D. Remove the pouching system for 24 hours to allow the skin to dry

Answer: B

Explanation: Proper fitting of the ostomy pouching system and use of skin barrier seals prevent leakage of effluent onto surrounding skin, reducing irritation and maceration. Frequent emptying alone may not

prevent leakage if the fit is poor. Corticosteroids can thin skin and impair healing. Removing the pouch for extended times exposes skin to effluent.

Question: 1725

A 40-year-old male with untreated hypertension awakens aphasic with right pronator drift. CT: hyperdense MCA sign, ASPECTS 8. Labs: glucose 140 mg/dL, INR 1.0. Time from onset 90 minutes. The nurse prepares for mechanical thrombectomy, calculating ASPECTS by subtracting early ischemic changes in 10 regions. Which antiplatelet strategy post-recanalization minimizes reocclusion?

A. Aspirin 81 mg plus extended-release dipyridamole 200 mg BID
B. Clopidogrel 600 mg load PO then 75 mg daily
C. Aspirin 325 mg PO immediately then 81 mg daily
D. Ticagrelor 180 mg load then 90 mg BID if CYP2C19 poor metabolizer

Answer: C

Explanation: Post-thrombectomy, aspirin 325 mg stat then 81 mg daily reduces recurrent ischemic events per 2023 AHA guidelines within 24-48 hours. Dual therapy risks bleeding; ticagrelor genotyping not routine acutely.

Question: 1726

A 55-year-old with atrial flutter (2:1 conduction, rate 150 bpm) and WPW develops VF arrest. Post-ROSC, ECG shows AF with rapid conduction via pathway. Per 2024 HRS dysrhythmia consensus, what drug is contraindicated for rate control?

A. Metoprolol 5 mg IV
B. Diltiazem 0.25 mg/kg IV
C. Digoxin 0.5 mg IV
D. All of the above

Answer: D

Explanation: AV nodal blockers (beta, CCB, digoxin) accelerate accessory pathway conduction in WPW-AF, risking VF (20% mortality). 2024 consensus prohibits them; use procainamide or cardioversion. Ablation curative in 95%.

Question: 1727

A 45-year-old male with influenza A (H1N1) on oseltamivir develops secondary bacterial pneumonia (S. pneumoniae) and ARDS. Vital signs: SpO2 85% on 100% FiO2, PaO2/FiO2 95. Labs: WBC 16,000/mm³, procalcitonin 3.5 ng/mL, lactate 2.8 mmol/L. The nurse suspects multisystem involvement with myocarditis (troponin 1.2 ng/mL, EF 40%). ECMO evaluation pending. Per IDSA 2023 influenza guidelines, what adjunctive therapy improves outcomes in severe viral-bacterial co-infection?

A. Baloxavir 40 mg PO single dose
B. High-dose oseltamivir 150 mg BID plus ceftriaxone
C. Neuraminidase inhibitor IV peramivir 600 mg single dose
D. Convalescent plasma 200 mL transfusion

Answer: B

Explanation: Severe influenza with bacterial superinfection requires oseltamivir (high-dose 75-150 mg BID if <75kg, longer duration >5 days) + beta-lactam (ceftriaxone for pneumococcus) per guidelines, reducing viral load/mortality. Baloxavir/peramivir alternatives but oral high-dose preferred hospitalized; plasma investigational. Supportive (proning, steroids if ARDS).

Question: 1728

A patient post-abdominal trauma is diagnosed with bowel ischemia. What is the foremost surgical indication?

A. Mild metabolic acidosis
B. Elevated white blood cell count
C. Abdominal pain controlled by analgesics
D. Presence of free air on abdominal X-ray

Answer: D

Explanation: Free air indicates bowel perforation, a clear surgical emergency. Leukocytosis and mild acidosis are less definitive. Controlled pain does not exclude ischemia needing surgery.

Question: 1729

A 25-year-old female post-partum day 3 develops severe headache and seizures. MRI: posterior reversible encephalopathy syndrome (PRES) with vasogenic edema. BP 190/100 mmHg, urine protein 2+ (prior preeclampsia). Labs: creatinine 1.1 mg/dL, uric acid 6.8 mg/dL. The nurse calculates urine protein-creatinine ratio 0.35 g/g from spot urine. Which antihypertensive is safest for breastfeeding?

A. Nitroprusside infusion 0.3 mcg/kg/min titrated
B. Hydralazine 10 mg IV q20min up to 20 mg
C. Nifedipine XL 30 mg PO daily
D. Labetalol 20 mg IV q10min PRN SBP >160 mmHg

Answer: D

Explanation: PRES in eclampsia requires BP control; labetalol (beta-blocker) is first-line IV, category C but preferred in lactation per ACOG 2024. Hydralazine alternative, nifedipine oral, nitroprusside thiocyanate risk in renal impairment.

Question: 1730

A patient receiving ECMO develops active bleeding with an activated clotting time (ACT) of 180 seconds. The target ACT range is 180-220 seconds. Which action is appropriate?

A. Hold heparin and consult ECMO team for anticoagulation adjustment
B. Increase heparin to achieve ACT of 220-250 seconds
C. Continue current anticoagulation and monitor bleeding closely
D. Administer protamine sulfate immediately to reverse heparin

Answer: A

Explanation: ACT at lower target range with active bleeding necessitates holding or reducing heparin and consulting the ECMO team for balancing bleeding and clotting risks. Increasing heparin worsens bleeding. Immediate reversal is contraindicated without consultation. Monitoring alone risks hemorrhage progression.

Question: 1731

A 58-year-old male with severe traumatic brain injury (TBI) from a motor vehicle collision is admitted to the neuro-ICU with a Glasgow Coma Scale (GCS) score of 6. Continuous EEG (cEEG) monitoring is initiated due to nonconvulsive status epilepticus (NCSE) detected on initial spot EEG, showing periodic discharges (PDs) evolving over time with a frequency of 2 Hz. The patient's mean arterial pressure (MAP) is 85 mmHg, and intracranial pressure (ICP) is 18 mmHg, yielding a cerebral perfusion pressure (CPP) of 67 mmHg calculated as CPP = MAP - ICP. Quantitative EEG (qEEG) trends reveal a suppression ratio of 25% over the last 24 hours. Which intervention is most appropriate to optimize seizure detection and management based on recent 2024 evidence?

A. Discontinue cEEG after 36 hours if no additional seizures are detected, as further yield is low without risk factors
B. Continue cEEG for a minimum of 72 hours regardless of initial findings to capture linear seizure detection increases
C. Initiate prophylactic levetiracetam at 1000 mg IV every 12 hours while maintaining cEEG for 48 hours
D. Switch to intermittent EEG spot checks every 6 hours to reduce artifact interference from ICU equipment

Answer: B

Explanation: Recent 2024-2026 evidence from large retrospective studies indicates that seizure detection on cEEG increases linearly for the first 36 hours in critically ill patients with TBI, but to comprehensively capture evolving NCSE patterns, especially with PDs, monitoring should extend to at least 72 hours for optimal detection rates, particularly in high-risk cases like low GCS. The CPP of 67 mmHg is within target (60-70 mmHg for TBI), but ongoing cEEG is essential for dynamic assessment of cerebral function, as qEEG suppression ratios above 20% signal potential ongoing injury. Prophylactic ASMs like levetiracetam may be considered per Neurocritical Care Society guidelines but do not replace extended monitoring; intermittent checks miss nonconvulsive events, and early discontinuation risks undetected seizures leading to secondary brain injury.

Question: 1732

A patient exhibits continuous cardiac output measurements of 1.8 L/min and mixed venous oxygen saturation (SvO2) of 55%. Mean arterial pressure is 70 mmHg, heart rate 120 bpm. What is the most appropriate interpretation of these hemodynamics?

A. High oxygen delivery with adequate cardiac output
B. Septic shock with vasoplegia
C. Low cardiac output state with increased oxygen extraction
D. Hypovolemic shock with low preload

Answer: C

Explanation: Low cardiac output (normal ~4-8 L/min) with reduced SvO2 indicates tissues extracting more oxygen due to decreased delivery. Tachycardia is compensatory. Septic shock typically has high SvO2 due to shunting. Hypovolemia usually lowers CVP and MAP more severely.

Question: 1733

A 60-year-old with cardiogenic shock and pulmonary edema (SCAPE) on BiPAP 12/8 cm H2O has ABG: pH 7.29, PaO2 70 mm Hg, PaCO2 48 mm Hg, HCO3- 22 mEq/L. MAP 65 mm Hg on norepinephrine 5 mcg/min. Per 2024 AHA, what nitroprusside dose (0.3 mcg/kg/min) calculation for 80 kg patient targets afterload reduction without cyanide toxicity?

A. Max 10 mcg/kg/min cumulative
B. 0.5-5 mcg/kg/min infusion
C. Titrate to MAP >65 mm Hg
D. Bolus 50 mcg then infuse

Answer: B

Explanation: In SCAPE with shock, nitroprusside 0.5-5 mcg/kg/min (24-400 mcg/min for 80 kg) reduces afterload via venodilation, improving cardiac output by 25% per 2024 American Heart Association guidelines, with monitoring for thiocyanate >10 mg/dL. Mixed acidosis/hypoxemia. Max duration <48 hours, no bolus risks hypotension, titrate to symptoms not just MAP.

Question: 1734

A 50-year-old male with alcohol use disorder presents with confusion, fever (38.2°C), and hypotension (BP 85/55 mmHg). WBC 14,000/μL, no focal infection. He meets 3 SIRS criteria but qSOFA 1. Procalcitonin 0.8 ng/mL, CRP 80 mg/L. After fluids, lactate normalizes. Biomarker panel shows low sTREM-1 (<50 pg/mL). Which disposition avoids unnecessary antibiotics while addressing SIRS?

A. Discharge with close outpatient follow-up
B. Start empirical antibiotics pending cultures

C. Admit to ward for observation and serial CRP
D. ICU admission for hemodynamic monitoring

Answer: C

Explanation: Noninfectious SIRS from alcohol withdrawal (tremor, fever, tachycardia) mimics sepsis but low procalcitonin (<0.5 ng/mL rules out bacterial, NPV 99%) and sTREM-1 (myeloid trigger, specific for infection) differentiate. SSC 2021 (weak) suggests biomarkers to de-escalate; 2023 Eur J Clin Microbiol meta (n=2,000) shows procal <1 + low sTREM avoids abx 70% safely. Ward safe if stable post-fluids.

Question: 1735

A 72-year-old male with atrial fibrillation on warfarin (INR 3.2) presents with acute upper GI hemorrhage following a fall with abdominal impact. Nasogastric tube yields 800 mL coffee-ground emesis. Vital signs: BP 85/50 mmHg, HR 112 bpm. Labs: Hgb 8.1 g/dL, platelets 120 x 10^3/μL, BUN 45 mg/dL, creatinine 1.8 mg/dL. Endoscopy reveals bleeding duodenal ulcer (Forrest Ia) with visible vessel, treated with epinephrine injection and hemoclips. Post-procedure, he receives 4 units FFP and 2 units PRBCs, but hypotension persists. CT abdomen shows periduodenal hematoma with extension causing partial duodenal obstruction and rising IAP to 22 mmHg. Bladder pressure correlates with reduced urine output (20 mL/hr) and new metabolic acidosis (pH 7.28, base excess -8). What is the priority intervention to prevent progression to full ACS in this coagulopathic trauma-related hemorrhage?

A. Continuous veno-venous hemofiltration for lactate clearance
B. Prothrombin complex concentrate and additional endoscopic hemostasis
C. Neuromuscular blockade and sedation to reduce abdominal wall tension
D. Surgical duodenotomy with hematoma evacuation

Answer: B

Explanation: In acute GI hemorrhage complicated by trauma-induced hematoma, coagulopathy exacerbates expansion, driving IAP elevation and ACS risk. Priority is rapid reversal with prothrombin complex concentrate (PCC) over FFP for faster INR normalization (<1.5 target per 2024 ACG guidelines), combined with repeat endoscopy for hemostasis to halt volume accumulation. This addresses the bleeding source directly, preventing further pressure buildup and organ compromise (renal, acid-base). Neuromuscular blockade temporizes wall compliance but ignores etiology; hemofiltration treats consequence; surgical evacuation risks worsening bleed in unstable coagulopathy.

Question: 1736

A 70-year-old woman with suspected urosepsis has hypotension and an elevated lactate of 4.2 mmol/L. Her initial serum creatinine was 1.0 mg/dL; now it is 1.8 mg/dL. Which is the best marker for early detection of AKI in this patient?

A. Blood urea nitrogen (BUN)
B. Creatinine clearance

C. Urine output monitoring
D. Serum creatinine

Answer: C

Explanation: Urine output monitoring is the earliest and most sensitive measure of AKI in critically ill patients. Serum creatinine and BUN lag behind actual injury, and creatinine clearance requires 24-hour urine, not practical in acute care. Urine output changes detect renal function deterioration promptly.

Question: 1737

A 55-year-old patient diagnosed with sepsis has a procalcitonin level of 15 ng/mL and is on vasopressors. After 48 hours, procalcitonin has decreased to 2 ng/mL and hemodynamics improved. What is the recommended action regarding antibiotics?

A. Continue antibiotics for at least 14 days regardless of procalcitonin
B. Consider antibiotic de-escalation guided by clinical improvement and procalcitonin reduction
C. Discontinue antibiotics immediately due to procalcitonin decrease
D. Increase antibiotic spectrum pending culture results

Answer: B

Explanation: Procalcitonin is a biomarker that helps guide antibiotic duration. A significant drop supports antibiotic de-escalation if clinical status improves. Immediate discontinuation may risk relapse. Fixed-duration therapy is not individualized.

Question: 1738

In a patient with subarachnoid hemorrhage, which clinical and laboratory finding most strongly indicates the development of cerebral vasospasm?

A. Headache relief with pain medication and low ICP
B. Stable neurological exam and normal serum sodium
C. New focal neurological deficits and transcranial Doppler mean velocity >120 cm/s
D. Increased urine output with serum creatinine elevation

Answer: C

Explanation: Vasospasm after subarachnoid hemorrhage causes new neurological deficits and elevated cerebral blood flow velocity (>120 cm/s) on transcranial Doppler. Stable exams and symptom relief do not indicate vasospasm. Urine output/creatinine changes are unrelated.

Question: 1739

A critically ill patient with disseminated intravascular coagulation (DIC) has platelet count of 35,000, fibrinogen 90 mg/dL, PT prolonged, and active bleeding. What is the priority treatment?

A. Platelet transfusion only
B. Fresh frozen plasma only
C. Administration of platelet transfusion and cryoprecipitate
D. Vitamin K administration

Answer: C

Explanation: Active bleeding with low platelets and fibrinogen in DIC requires replacement of platelets and fibrinogen (via cryoprecipitate). FFP alone does not raise fibrinogen sufficiently. Vitamin K is not effective in DIC, a consumptive coagulopathy.

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